MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 11615

1. PLACE OF DEATH:

County: Washington

City or town: Cascade (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 36 days

Hospital, institution, or street address where death occurred: Fitzhugh Hosp.

How long in hospital or institution? 36 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 2404 E. Oliver St (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Amelia Agnes Baird

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: Maurice Albert Baird - Deceased

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 3 1882

8. AGE: Years: 65 Months: 9 Days: 24 If less than one day: ..... hrs. ..... min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business:

FATHER 12. Name: Emanuel Manners

FATHER 13. Birthplace: Baltimore

MOTHER 14. Maiden name: Cecelia Kellerman

MOTHER 15. Birthplace: Balto Md.

16. Informant: Dallie Hirshenthal

Address: 2404 E. Oliver St

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-30-47 (month) (day) (year)

Cemetery or crematory: Holy Redeemer Cem.

Location: Belair Road

16. Funeral director: John P. Mullen Inc

Address: 2435 E. Oliver St

19. 12/29/47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 27 19 47 at 6 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 20 19 47 to Dec 27 19 47 and that I last saw h.. alive on Dec 27 19 47

Immediate cause of death	DURATION
(Clinical impression) Carcinomatosis	
Primary site undetermined	
Due to	
Due to	
Other conditions: Arteriosclerosis	
Arthritis	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Thomas M. Assington M. D. or other

Address: Fitzhugh Hosp. Cascade, Md. Date signed Dec 29 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932

11616

Reg. Dist. No. 382

1. PLACE OF DEATH:
County Washington
City or town Hagerstown 8.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, institution, or street address where death occurred:
328 N. Jonathan Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 328 N. Jonathan Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Lewis Albert Barnes

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 6, 1908

8. AGE: Years	Months	Days	If less than one day
39	9	27	hrs. min.

9. Birthplace Hagerstown, Wash, Maryland
(Town, county, and state)
10. Usual occupation Not employed
11. Industry or business

FATHER
12. Name James Albert Barnes
13. Birthplace Mercersburg Pa

MOTHER
14. Maiden name Elizabeth Clark
15. Birthplace Cattles Mill, Md.

16. Informant Mrs. Elizabeth Barnes
Address 328 N. Jonathan Street

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/5/47 (month) (day) (year)
Cemetery or crematory Rose Hill Cemetery
Location Hagerstown, Md.

18. Funeral director William H Downey
Address 291 Frederick Street

19. Dec 5. 1947 Chas H Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 3, 1947, at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 1947 to Dec. 3 1947
and that I last saw h... alive on Nov 28 1947

Immediate cause of death	DURATION
Coronary Occlusion Heart Disease	1 yr.
Due to	
Due to	
Other conditions Cerebral Hemorrhage Arteriosclerosis.	1 yr.

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Henry J. McLean MD
M. D. or other
Address 159 W. Washington St Date signed 12/5/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11617

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 years
Hospital, institution, or street address where death occurred: 317½ N. Jonathan Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 317½ N. Jonathan Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Ada Zela Barnett

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Widow

6.(b) Name of husband or wife Benjamin Barnett
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) May 12, 1866

8. AGE: Years	Months	Days	If less than one day hrs. min.
81	7	4	

9. Birthplace Williamsport, Wash., Md (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Ralph Boss
13. Birthplace Williamsport, Md
MOTHER 14. Maiden name Margaret Boss
15. Birthplace Williamsport, Md
16. Informant Miss Madeline Barnett
Address 317½ N. Jonathan Street
17. Burial (Burial, cremation, or removal, Which?) Date thereof 12-19-47 (month) (day) (year)
Cemetery or crematory Riverview Cemetery
Location Williamsport Md.
18. Funeral director William H Downey
Address 291 Frederick St Hagerstown
19. Dec. 19. 1947 Chas H. Bowers (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 16 1947, at 1 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1st 1947, to Dec 16 1947
and that I last saw her alive on Dec 15 1947

	DURATION
Immediate cause of death Cerebral Hemorrhage	1 day
Due to	
Due to	
Other conditions Arteriosclerosis.	?
Hypertension	?

(Include pregnancy within 3 months of death)
Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE [illegible] M.D. (M. D. or other)
Address 159 W Washington St Date signed 12/18/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11618

Reg. Dist. No. .....

1. PLACE OF DEATH:
County Washington
City or town Cascade
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 mos 12 days
Hospital, Institution, or street address where death occurred:
Pitcher Hospital
How long in hospital or institution? 2 mos 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County .....
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 819 W Hoyt
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME Fred D Beck

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Georgianna
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) July 15 1879

8. AGE: Years	Months	Days	If less than one day
68	6	11	..... hrs. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual occupation Newspaper Cont Salesman
11. Industry or business Own Store
FATHER 12. Name Ernest Beck
13. Birthplace Baltimore Md
MOTHER 14. Maiden name Mary Ahrens
15. Birthplace Baltimore Md
16. Informant Wilbur E Beck
Address 3121 Normount Ave
17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-29-47 (month) (day) (year)
Cemetery or crematory Nat Cathedral
Location Baltimore Md
18. Funeral director Wilbur E Beck Inc
Address 1217 E Cont St
19. Dec 29 1947 (Date rec'd by registrar) A W Le Brun Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26 1947 at 11 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 14 1947 to Dec 26 1947 and that I last saw h alive on Dec. 26 1947

Immediate cause of death	DURATION
Bronchogenic Carcinoma	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury Injured at work?

23. SIGNATURE Thomas M. Arrington M.D.
M. D. or other
Address Pitcher Hospital Cascade Md Date signed Dec 26 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11619

932

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

836 Rose Hill Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 836 Rose Hill Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Frederick M. Bloom

3.(b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary M. Bloom

6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): May 4, 1874

8. AGE:

Years	Months	Days	If less than one day
73	7	20	....hrs. ....min.

9. Birthplace: Hagerstown, Wash. Co. Md.

(Town, county, and state)

10. Usual occupation: Retired Merchant

11. Industry or business

FATHER — 12. Name: George Bloom

13. Birthplace: Hagerstown, Maryland

MOTHER — 14. Maiden name: Caroline Shupp

15. Birthplace: Funkstown, Maryland

16. Informant: Mrs. Fred. M. Bloom

Address: Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-26-47 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown, Maryland

18. Funeral director: C. M. Suter & Sons

Address: Hagerstown, Maryland

19. Dec 24, 1947 (Date rec'd by registrar) Chas H Bowers, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 24 Dec 1947 at 530A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 1935 to 24 Dec 1947 and that I last saw h[illegible] alive on 23 Dec 1947

Immediate cause of death	DURATION
Arteriosclerotic Cardio Vascular Disease	15yrs +
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: DNA

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: F F Suter, M. D. or other

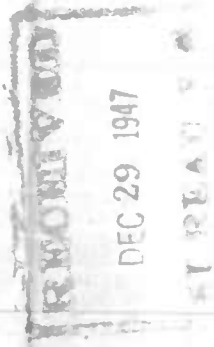
Address: 230 N Potomac Date signed: 24 Dec 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Dr. Lusby



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11620

1572

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: WASHINGTON
City or town: HAGERSTOWN
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 DAYS
Hospital, institution, or street address where death occurred:
WASHINGTON COUNTY HOSPITAL
How long in hospital or institution? 2 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: WASHINGTON
City or town: HAGERSTOWN
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 944 CORBETT ST.
(If rural, give LOCATION)
2.(a) If veteran, name war: NON-VET.

3.(a) FULL NAME: MICHAEL ALLEN BOWARD

3.(b) Social Security Number: NONE

4. Sex: MALE
5. Color or race: WHITE
6.(a) Single, married, widowed, or divorced: SINGLE

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): DECEMBER 22, 1947

8. AGE: Years | Months | Days: 2 | If less than one day: hrs. min.

9. Birthplace: HAGERSTOWN, WASHINGTON, MD.
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: ROSCOE W. BOWARD
13. Birthplace: R.F.D.#6, HAGERSTOWN, MD.

MOTHER
14. Maiden name: MARIAN E. HARBAUGH
15. Birthplace: SMITHSBURG, MD.

16. Informant: Marian E. Boward
Address: 944 Corbett St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12/26/47 (month) (day) (year)
Cemetery or crematory: Smithsburg Cemetery
Location: SMITHSBURG, MD.

18. Funeral director: Woodford J. Norment
Address: Hagerstown, Md.

19. Dec. 26, 1947 (Date rec'd by registrar) Chas. H. Boward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12-24-47, 19..., at 10 15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-23, 19 47, to 12-24, 19 47
and that I last saw h.i.m. alive on 12-24, 19 47

Immediate cause of death	DURATION
Congenital Cerebral Defect	Birth.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Congenital Mal. of Kidneys, Ureters and Bladder
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. Margaret Sullivan M.D.
M. D. or other
Address: 135 N. Potomac St. Date signed: 12-26-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Margaret Sullivan
135 N. Potomac St

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a 11621

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Maugansville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, Institution, or street address where death occurred:
Residence Maugansville, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Maugansville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Benjamin Wesley Breeden

3.(b) Social Security Number: 214-09-9657

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Helen E. Breeden
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): April 23, 1893
8. AGE: Years: 54 Months: 7 Days: 22 If less than one day: ... hrs. ... min.
9. Birthplace: Elkton -Rockingham Co., Va.
(Town, county, and state)
10. Usual occupation: Taxi Driver
11. Industry or business
FATHER 12. Name: Henry Breeden
13. Birthplace: Rockinghem Co., Va.
MOTHER 14. Maiden name: Armita -------
15. Birthplace: Rockingham Co., Va.
16. Informant: Mrs. Helen E. Breeden
Address: Maugansville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 18, 1947 (month) (day) (year)
Cemetery or crematory: St. Paul's Cemetery
Location: Route 40 W. of Hagerstown, Md.
18. Funeral director: Fred W. Kraiss
Address: Hagerstown, Md.
19. Dec. 17 1947 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 15, 1947 12:50 at A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 14-47 19... to Dec 15-47 19...
and that I last saw him alive on Dec 14-47 19...

	DURATION
Immediate cause of death	
Coronary Thrombosis	22 hr
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ... Injured at work?

23. SIGNATURE: I W Walls M. D. or other
Address: Hagerstown Md Date signed 12/17/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11622

928

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 years

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 27 North Jonathan St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Pauline F. Burger

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Fred A. Burger

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): July 11, 1906

8. AGE: Years	Months	Days	If less than one day
41	5	0	____ hrs. ____ min.

9. Birthplace: Steelton, Penna. (Town, county, and state)

10. Usual occupation: Hairdresser

11. Industry or business:

FATHER

12. Name: Paul M. Ney

13. Birthplace: Schuykill County Penna.

MOTHER

14. Maiden name: Mary Butfington

15. Birthplace: Schuykill County Penna.

16. Informant: Fred A. Burger

Address: 27 N. Jonathan St. Hagerstown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 14, 1947 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown, Maryland

18. Funeral director: Fred W. Kraiss

Address: Hagerstown, Maryland

19. Dec. 14 1947 (Date rec'd by registrar) Chas. H. Beaver Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 11 1947, at 8:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-14 1947 to 12-11 1947 and that I last saw h-ea alive on 12-11- 1947

Immediate cause of death	DURATION
Pulmonary Embolism	½ hour
Due to: Rheumatic Heart Disease & Mitral Stenosis and Insufficiency	25 yrs
Due to: Chronic Asthmatic Bronchitis	6 yrs
Other conditions: Myoma of Uterus	?

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: Dallas M. Welty M.D. M. D. or other

Address: Hagerstown Maryland Date signed: 12-13-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

928 11623

CERTIFICATE OF DEATH

Reg. Dist. No. 306

1. PLACE OF DEATH:
County Washington
City or town Cascade, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, institution, or street address where death occurred:
Ritchie Hospital
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Howard
City or town Ellicot City
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME Samuel Rogers Burgess

3. (b) Social Security Number 212-07-6698

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 5, 1886

8. AGE: Years	Months	Days	If less than one day
61	3	15	hrs. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Grave Digger
11. Industry or business
FATHER 12. Name Samuel Rogers Burgess
13. Birthplace Maryland
MOTHER 14. Maiden name Sarah Harrison
15. Birthplace Maryland
16. Informant Martha Martin
Address Ellicott City Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-24-47 (month) (day) (year)
Cemetery or crematory Good Shepherd
Location Ellicott City Md
18. Funeral director H. C. Dyer Lothern
Address Ellicott City Md
19. 12/23 1947 (Date rec'd by registrar) D. W. Dodrer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 20 1947, at 11:50 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 17 1947 to Dec 20 1947
and that I last saw him alive on Dec 20 1947

Immediate cause of death	DURATION
Cardiac failure	2 months
Due to Chronic Valvular Disease - mitral & tricuspis	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Thomas M. Arrington M.D.
M. D. or other
Address Ritchie Hospital Date signed Dec 24, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

11624

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

73a

CERTIFICATE OF DEATH

Reg. Dist. No. 3 c 3

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Washington
City or town: Rural Hagerstown Route 40
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year
Hospital, institution, or street address where death occurred:
Gateway Convalesing Home
How long in hospital or institution? 1 year

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Pennsylvania County: Franklin
City or town: Greencastle, Pa.
(If outside city or town limits, write RURAL and give nearest town)
Street No. -------
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Mary Ellen Carl

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 13, 1874

8. AGE: Years	Months	Days	If less than one day
73	7	21	hrs. min.

9. Birthplace: Greencastle-Franklin- Pa. (Town, county, and state)
10. Usual occupation: None
11. Industry or business:

FATHER
12. Name: John Carl
13. Birthplace: Greencastle, Pa.

MOTHER
14. Maiden name: Martha Wingerd
15. Birthplace: Mercersburg, Pa.

16. Informant: John J. Carl
Address: Greencastle, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 7-47 (month) (day) (year)
Cemetery or crematory: Cedar Hill Cemetery
Location: Greencastle, Pa.
18. Funeral director: A. E. Minnich
Address: Greencastle, Pa.

19. Dec 6 (Date rec'd by registrar) 19 47 Lewis M. Fahler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 5 19 47, at 12 05 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 26 19 47 to Dec. 5 19 47 and that I last saw h. alive on Dec. 5 19 47

Immediate cause of death	DURATION
PERNICIOUS ANEMIA	?
Due to TERMINAL HYPOSTOTIC Pneumonia	1 day.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None. Date of op. —
Autopsy results: None.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Archie Robert Cohen M. D.
Address: Clear Spring Md Date signed: 12-5-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11625

93d

Reg. Dist. No. 305

Dr. Shady.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(I)

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Washington

City or town: Mt. Lena "Rural"

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, institution, or street address where death occurred: Boonsboro Md. R. 2

How long in hospital or institution? at Home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Mt. Lena "Rural"

(If outside city or town limits, write RURAL and give nearest town)

Street No. Boonsboro Md. R. 2

(If rural, give LOCATION)

2.(a) If veteran, name war: No.

3.(a) FULL NAME: Ira Elmer Draper

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Florence Zachler Draper

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 27 1868

8. AGE:

Years	Months	Days	If less than one day
78	11	27	..... hrs. ..... min.

9. Birthplace: Thurmont Fred. Co. Md. (Town, county, and state)

10. Usual occupation: Retired Farmer

11. Industry or business

FATHER

12. Name: No Record

13. Birthplace: " "

MOTHER

14. Maiden name: No Record

15. Birthplace: " "

16. Informant: Mrs. Ester Irving

Address: Boonsboro Md. R. 2

17. Burial (Burial, cremation, or removal. Which?) Date thereof: December 27 1947 (month) (day) (year)

Cemetery or crematory: Mt Lena Cemetery

Location: Mt. Lena Md.

18. Funeral director: Wm. D. Bast & Sons

Address: Boonsboro Md.

19. Dec. 27. 1947 (Date rec'd by registrar) John W. Bast Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 24, 1947, at 6 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Treated by U. S. V. A. Hospital own 1 year. 19.. to 19.. and that I last saw h.. alive on Post Mortem 12/24 1947.

Immediate cause of death	DURATION
Chronic Myocarditis.	1 yr +.
Due to Hypertrophic Arteriosclerosis and Arteriosclerotic Heart Disease	1 yr +.
Due to	
Other conditions Hemiplegia.	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Walter D. Shady M.D. M. D. or other

Address: [illegible] Date signed 12/26/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

11626

CERTIFICATE OF DEATH

Reg. Diat. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years

Hospital, institution, or street address where death occurred: 250 S. Potomac St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 250 S. Potomac St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Charles C. Dysert

3.(b) Social Security Number: 213-12-7359

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Josephine A.

6.(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): February 8, 1888

8. AGE: Years	Months	Days	If less than one day
59	9	29	....hrs. ....min.

9. Birthplace: Carlisle Pa. (Town, county, and state)

10. Usual occupation: Purchaseing Agent

11. Industry or business: City of Hagerstown

FATHER — 12. Name: Daniel Dysert

FATHER — 13. Birthplace: Waynesboro Pa.

MOTHER — 14. Maiden name: Minnie Cornman

MOTHER — 15. Birthplace: Carlisle Pa.

16. Informant: Mrs. Josephine Dysert

Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-9-47 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown Md.

18. Funeral director: Scott F. Minnich & Son

Address: Hagerstown Md.

19. Dec. 9. 1947 (Date rec'd by registrar) Chas H Boward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 7 1947 at 7:30a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 6 1947, to Dec 7 1947 and that I last saw h.. im..alive on Dec 6 1947

Immediate cause of death	DURATION
Coronary Thrombosis	12/6/47
Due to	
Due to	
Diher conditions	

(Include pregnency within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. L. Porterfield M.D. M. D. or other

Address: 136 W Washington Date signed 12/8/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

50X

11627

Reg. Dist. No. 307

1. PLACE OF DEATH:
County Washington
City or town (Rural) Dargan
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 58 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town (Rural) Dargan
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME Katie Irene Eichelberger

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife George Lee Eichelberger
6.(c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) January 29, 1874

8. AGE: Years	Months	Days	If less than one day
73	10	19	hrs. min.

9. Birthplace Jefferson County, West Va. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Own Home

FATHER
12. Name Thomas Welsh
13. Birthplace Harpers Ferry, West Va.

MOTHER
14. Maiden name Annie Murphy
15. Birthplace Unknown

16. Informant Mr. George L. Eichelberger
Address R.F.D.#1, Harpers Ferry, W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/20/47 (month) (day) (year)
Cemetery or crematory Samples Manor Cemetery
Location Samples Manor, Maryland
18. Funeral director Melvin T. Shindler
Address Charles Town, West Va.

19. Dec 14 19 47 (Date rec'd by registrar) Cornelius W. Lantz Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 18, 19 47, at 3:15A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 43 to December 18 19 47
and that I last saw h alive on December 17 19 47

Immediate cause of death — DURATION
Carcinoma of Lft Breast
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE G W Gilbert M.D.
M. D. or other
Address Boonsboro Md Date signed 12/19/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

11628

Victor Miller

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 31 Years

Hospital, institution, or street address where death occurred:

653 Oak Hill Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 653 Oak Hill Ave

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: Charles H. Eyerly

3.(b) Social Security Number: No

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Nancy

6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): January 23, 1867

8. AGE: Years	Months	Days	If less than one day
80	10	7	...hrs. ...min.

9. Birthplace: Williamsport, Wash. Co. Md (Town, county, and state)

10. Usual occupation: Merchant

11. Industry or business: Own Store

FATHER — 12. Name: Gerorge W. Eyerly

13. Birthplace: Funkstown, Md

MOTHER — 14. Maiden name: Susan Kendell

15. Birthplace: Williamsport, Md

16. Informant: Mrs Charles H. Eyerly

Address: Hagerstown, Md,

17. Burial (Burial, cremation, or removal, Which?) Date thereof: Dec. 20, 1947 (month) (day) (year)

Cemetery or crematory: Rose Hill Mausoleum

Location: Hagerstown, Md

18. Funeral director: Andrew K. Coffman

Address: Hagerstown, Md

19. Dec. 20, 1947 (Date rec'd by registrar) Clark Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec, 18, 1947 at 4:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 — 1947 to 12/18 1947

and that I last saw him alive on 12/18 1947

Immediate cause of death	DURATION
cerebral embolus	2 ?
arterio-sclerosis	2
Due to Myocarditis.	2 —
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ✓ Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Victor D. Miller M. D. or other

Address: 131 W. WASHINGTON ST. Date signed: 12/18/1947

DR. VICTOR D. MILLER

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11629

940

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 years
Hospital, Institution, or street address where death occurred:
49 Summit Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 49 Summit Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: Spanish & World War #1

3.(a) FULL NAME: Grant U. Fleming

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mabel J. Fleming
6.(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): April 26, 1870

8. AGE: Years	Months	Days	If less than one day
77	7	11	....hrs. ....min.

9. Birthplace: Gettysburg, Pa.
(Town, county, and state)

10. Usual occupation: Painter

11. Industry or business: Sherwood Brothers

FATHER
12. Name: John Fleming
13. Birthplace: Gettysburg, Pa.

MOTHER
14. Maiden name: Mabel Baxter
15. Birthplace: Steelton, Pa.

16. Informant: Grant A. Fleming
Address: Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-9-47 (month) (day) (year)
Cemetery or crematory: Rest Haven Cemetery
Location: Hagerstown, Maryland

18. Funeral director: C. M. Suter & Sons
Address: Hagerstown, Maryland

19. Dec. 9, 1947 (Date rec'd by registrar) Elsie H. Howard Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7 Dec 1947 at 11:A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 5 Dec 1947 to 7 Dec 1947 and that I last saw h... alive on 5 Dec 1947

Immediate cause of death	DURATION
Coronary Thrombosis	2 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Edmund H. Earhart MD
M. D. or other
Address: 115 W. Wash St. Date signed: 12/8/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Ditto

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932

Reg. Dist. No. 11630 2

1. PLACE OF DEATH:

County Washington

City or town Hagerstown R # 4
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Years

Hospital, institution, or street address where death occurred:
Broadfording Road

How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown R # 4
(If outside city or town limits, write RURAL and give nearest town)

Street No. Broadfording Road
(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME WILLIAM DANIEL P FLOOK

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife Louise

6.(c) If alive, give age -

7. Birth date of deceased (mo., day, yr.) December 30 1868

8. AGE: Years	Months	Days	If less than one day
78	11	27	hrs. min.

9. Birthplace Myersville Fred. Co. Md.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Retired

FATHER 12. Name Jonas L. Flook

13. Birthplace Myersville Md.

MOTHER 14. Maiden name Anna Flook

15. Birthplace Myersville Md.

16. Informant Mrs. Cora Hastings

Address Hagerstown Md. R # 4

17. Burial Date thereof 12/30/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Long Meadows Cemetery

Location near Paramount Md.

19. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. Dec. 29 19 47 Elsie H Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH December 27 1947 at 1.30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 - 47 to Dec 27 1947

and that I last saw him alive on Dec 26 47 1947

Immediate cause of death	DURATION
Cardio - Vascular Lesion	4 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W Dutt M. D. or other

Address Hagerstown Md. Date signed 12-29-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131a ; 11631

Reg. Dist. No. 305

1. PLACE OF DEATH:

County: Washington

City or town: Boonsboro
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:
Guilford Convalescent Home

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Clevelandville Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. Boonsboro R. 2.
(If rural, give LOCATION)

2.(a) If veteran, name war: No.

3. (a) FULL NAME: Otho James Ford

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Etta Haupt Ford

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May - 27 - 1860

8. AGE:

Years	Months	Days	If less than one day
87	6	29	..... hrs. ..... min.

9. Birthplace: Near Boonsboro Wash. Co. Md.
(Town, county, and state)

10. Usual occupation: Retired Fruit Growers.

11. Industry or business

FATHER
12. Name: Thomas Ford
13. Birthplace: Wash. Co. Md

MOTHER
14. Maiden name: Anna Easterday
15. Birthplace: Wash. Co. Md

16. Informant: Paul Ford

Address: Boonsboro Md. R. 2

17. Burial. (Burial, cremation, or removal. Which?) Date thereof Dec. 29 - 1947 (month) (day) (year)

Cemetery or crematory: Boonsboro Cemetery

Location: Boonsboro Md.

18. Funeral director: Wm. D. Bast & Sons

Address: Boonsboro Md.

19. Dec. 28. 1947 (Date rec'd by registrar) John W. Bast Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 26 1947 at 12:05 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 16 1947 to Dec. 26 1947; and that I last saw him alive on Post Mortem 12/26 1947.

Immediate cause of death	DURATION
Chronic Myocarditis	1 yr. +
Due to: Chronic Interstitial Nephritis	1 yr. +
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Walter W. Sprealy M.D. M. D. or other

Address: Keedysville, Md. Date signed 12/26/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Dr. Hirshman

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

156 a

11632

Reg. Dist. No. 702

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 Days
Hospital, institution, or street address where death occurred: Washington County Hospital
How long in hospital or institution? 10 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1715 Va. Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Mrs Margaret A Garrett

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: William
6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): Nov. 17 1893

8. AGE: Years	Months	Days	If less than one day
54	1	1	..... hrs. ..... min.

9. Birthplace: Moorefield W.Va.
(Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business: Own Home

FATHER
12. Name: Phillip Tusung
13. Birthplace: Moorefield W. Va.

MOTHER
14. Maiden name: Abigail Funkhouser
15. Birthplace: Moorefield, W. Va.

16. Informant: Willian Garrett
Address: Hagerstown ,Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 21, 1947 (month) (day) (year)
Cemetery or crematory: Rest Haven Cemetery
Location: Hagerstown MD.

18. Funeral director: Andrew K. Coffman
Address: Hagerstown .Md

19. Dec. 20. 1947 (Date rec'd by registrar) C Scott Howard Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 18th 1947, at 1:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 7th 1947, to Dec 18th 1947
and that I last saw her alive on Dec 18th 1947

	DURATION
Immediate cause of death: Acute Dilatation of Stomach	2 days
Due to: Malnutrition and General debility.	5 wks
Due to:	
Other conditions: (Include pregnancy within 3 months of death)	

Major findings of operations: Fusion – left knee – Nov. 8, 47
Partial ankylosis following fracture of left tibia into joint
Date of op. Nov. 8, 1947
Autopsy results: Dilatation of Stomach –

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: Oct 22, 1943
Where did injury occur? 1715 Virginia Avenue (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury: Fell about 3 ft. from [illegible] Injured at work? [1/26/48 [illegible]]

23. SIGNATURE: [illegible signature] M.D. (M. D. or other)
Address: 159 W. Washington St Date signed: 12/19/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11633

462 k

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH

County Washington

City or town Hagerstown Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, Institution, or street address where death occurred: Washington County Hospital

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Penna County Franklin

City or town Mercersburg R

(If outside city or town limits, write RURAL and give nearest town)

Street No. R D 2

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs Lydia Amanda Gayman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Tobias S. Gayman

6.(c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) Jan. 2 - 1880

8. AGE: Years	Months	Days	If less than one day
67	11	16	..... hrs. ..... min.

9. Birthplace Near Chambersburg Pa.

(Town, county, and state)

10. Usual occupation Home work

11. Industry or business

FATHER

12. Name Emanuel S. Maitie

13. Birthplace Cumberland Co. Pa.

MOTHER

14. Maiden name Martha E. Kruger

15. Birthplace Cumberland Co Pa

16. Informant Tobias Gayman

Address Mercersburg Pa R D 2

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 22 - 47 (month) (day) (year)

Cemetery or crematory Myers Welsh Run Pa.

Location

19. Funeral director H. M. Kissinger

Address Mercersburg Penna.

19. Dec. 20 1947 Chas H Bowers

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 18 1947 at 7:35 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/ 1947, to 12/18 1947

and that I last saw h.. alive on 12/ 18 1947

Immediate cause of death	DURATION
Carcinoma of Breasting	
Colon	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. M. Kissinger M. D. or other

Address Greencastle Pa Date signed 12/22/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

11634

Reg. Dist. No. 307

1. PLACE OF DEATH:

County: Washington

City or town: Harpers Ferry Bridge Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Yr

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? On Bridge

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Near Harpers Ferry Bridge
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: Unknown

3. (a) FULL NAME: Millard J. Goodhart

3. (b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Nettie Goodhart

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): About 1882

8. AGE: Years	Months	Days	If less than one day
65	-	-	..... hrs. ..... min.

9. Birthplace: No Record
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: -

FATHER
12. Name: No Record
13. Birthplace: " "

MOTHER
14. Maiden name: No Record
15. Birthplace: " "

16. Informant: Neighbors of deceased

Address

17. Burial - Date thereof: January 3, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Samples Manor Cemetery

Location: Samples Manor Md.

18. Funeral director: W. H. Bast & Sons

Address: Boonsboro Md.

19. Jan 2 1948 Mrs. Katherine Dagenhart
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 29 1947, at 11:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Chronic myocarditis	5 yrs.
Acute ventricular fibrillation	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op. .....

Autopsy results: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: None Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE: S. Robert Wells DEPUTY MEDICAL EXAM WASH. CO., MD.

M. D.

Address: Hagerstown, Md. Date signed 12/31/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

STATE OF MARYLAND—CERTIFICATE OF DEATH

19

159 11635

1. PLACE OF DEATH

County Washington Registration Dist. No. 316

Village or City Keedysville No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME ~~Baby~~ Harold Edward Guyer, Jr.

(a) Residence: No. St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
male	white	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, and year) December 25, 1947

7. AGE Years	Months	Days	If LESS than 1 day hrs. or 30 min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Keedysville, Md.
(State or country)

FATHER

13. NAME Gerald E. Guyer

14. BIRTHPLACE (city or town) Keedysville, Md.
(State or country)

MOTHER

15. MAIDEN NAME Anna Norris

16. BIRTHPLACE (city or town) Knoxville
(State or country) Md.

17. INFORMANT Gerald E. Guyer
(Address) Keedysville, Md

18. BURIAL, ~~CREMATION~~, OR REMOVAL
Place Rest Haven-Hagerstown Date Dec. 26 1947

19. UNDERTAKER R. I. Earnshaw
(Address) Keedysville, Md

20. FILED Dec. 26, 19 47 R. D. Fleeting
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH December 25, 1947. 193
(Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from at birth, 19, to, 19
I last saw him alive on Dec. 25, 1947, 19; death is said to have occurred on the date stated above, at 1:50 A. M.

The **PRINCIPAL CAUSE OF DEATH** and related causes of Importance were as follows:

	Date of onset
Prematurity - 23 weeks	
Spontaneous abortion of mother	
cause not determined.	
Other **Contributory Causes** of Importance:	

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur?
(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Walter W. Shea Jr. M. D.

(Address) Sharpsburg, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

Birth and Death

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF ~~STILLBIRTH~~ 159

Reg. Dist. No. 302

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:
   County: Washington
   City or town: Hagerstown
   (If outside city or town limits, write RURAL and give nearest town)
   Street address, hospital, or institution: Washington County Hospital
   Length of mother's stay in County: (How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER: 11636
   State: Maryland
   County: Washington
   City or town: Hagerstown
   (If outside city or town limits, write RURAL and give nearest town)
   Street No.: 49½ E. Franklin St.
   (If RURAL give LOCATION)

3. Name of child: Baby Girl Hankey
4. Date of birth: December 15 19 47 Hour: 2 A. M.
5. Sex: Female
6. Twin or triplet: 1
7. No. of ~~weeks~~ months pregnancy: 5 months

FATHER OF CHILD

8. Full name: Richard Brennaman Hankey
9. Color: White
10. Age at time of this birth: 30 yrs.
11. Usual occupation: Ice Cream Mfgr.

MOTHER OF CHILD

12. Full maiden name: Janet Mae Troxell
13. Color: White
14. Age at time of this birth: 24 yrs.
15. Usual occupation: Housewife

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 0
    (b) How many other children were born alive but are now dead? 0 (c) How many other children were *born* dead? 0

17. Did child die before labor? No During labor? No
18. Pregnancy, complications of:
19. Labor: (a) Complications of:
    (b) Induced? No
20. (a) Was there an operation for delivery? No (Yes or No)
    (b) State all operations, if any:
    (c) Did child die before operation?
    During operation?

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.
    (a) Fetal causes: Prematurity 5 mos
    (b) Maternal causes: Mother fell Rupturing membranes

22. I certify to the birth of this child who was born dead* on the date and hour above stated.
    Signature: H. L. Porterfield M.D.
    (Specify if M. D., midwife, or other)
    Address: Hagerstown, Md.

23. (a) Burial (Burial, cremation or removal) (b) Date thereof 12-16-47 (month) (day) (year)
    (c) Cemetery or crematory: Green Hill Cemetery
24. (a) Funeral director: Scott F. Mennard & Son
    (b) Address: Hagerstown Md

25. (a) Dec. 16 1947 (Date rec'd by registrar) (b) C. Earl Bowers (Registrar)

26. (To be filled out if no physician was present at delivery.) The above certificate has been examined by me.
    Health Officer, per

* See Instruction C on stub.

V. S. A10

Child Lived 3 hours

(I)

(T)

Dr. Hornbaker

11637

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 Hours

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution? 4 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1613 Virginia Ave

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: MRS FANNIE GERTRUDE HARBAUGH

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Fleet D.

6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): September 4 1888

8. AGE: Years	Months	Days	If less than one day
59	4	23	...hrs. ...min.

9. Birthplace: Hagerstown Wash. Co. Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER

12. Name: Zachariah Taylor

13. Birthplace: Mercersburg Pa.

MOTHER

14. Maiden name: Elizabeth Carbaugh

15. Birthplace: Hagerstown Md.

16. Informant: Fleet D. Harbaugh

Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/29/47 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown Md.

18. Funeral director: Andrew K. Coffman

Address: Hagerstown Md.

19. Dec. 29. 47 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

A

20. DATE OF DEATH: December 27 1947 at 1.30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/26 1947 to 12/27 1947

and that I last saw her alive on 12/27 1947

	DURATION
Immediate cause of death: Cerebral Hemorrhage	4 Hours
Due to: Hypertensive Vascular Disease	Unknown
Due to:	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John H. Hornbaker M. D. or other

Address: 57 W. Washington St. Hagerstown Md. Date signed 12/29/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11638

157d

CERTIFICATE OF DEATH

Reg. Diat. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution? 12-2-47

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother).

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 17 N. Mulberry St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME

Jack Martin Harbaugh

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 3, 1947

8. AGE: Years	Months	Days	If less than one day
	2	7	hrs. min.

9. Birthplace: Hagerstown, Washington Co. Maryland

(Town, county, and state)

10. Usual occupation:

11. Industry or business

FATHER — 12. Name: Martin Harbaugh

13. Birthplace: Hagerstown, Maryland

MOTHER — 14. Maiden name: Alice Starliper

15. Birthplace: Mercersburg, Penna.

16. Informant: Martin Harbaugh

Address: 17 N. Mulberry St, Hagerstown, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 12, 1947 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown, Maryland

18. Funeral director: Fred W. Kraiss

Address: Hagerstown, Maryland.

19. Dec. 12 19 47 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 10 19 47, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-30 19 47 to 12-10 19 47 and that I last saw him alive on 12-9-47 19

Immediate cause of death	DURATION
Malnutrition	
Due to: Congenital Malformation of the Brain	Since birth
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: E. Margaret Sullivan M.D.

M. D. or other

Address: 135 N. Potomac St. Date signed: 12-11-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932 11630

Reg. Dist. No. 304

1. PLACE OF DEATH:
County: Washington
City or town: Rural – Hancock
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Rural – Hancock
(If outside city or town limits, write RURAL and give nearest town)
Street No.: U. S. Route 40 – East of Hancock
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME: Helen A. Harp

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Roy P. Harp
8.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): April 8, 1884

8. AGE: Years	Months	Days	If less than one day
63	7	23	____ hrs. ____ min.

9. Birthplace: Mapleville, Wash. Co., Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: —

FATHER
12. Name: Moses Rudisill
13. Birthplace: Mapleville, Md.

MOTHER
14. Maiden name: Jane Rebecca Smith
15. Birthplace: Mapleville, Md.

16. Informant: Roy P. Harp
Address: Route #2, Hancock, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 3, 1947 (month) (day) (year)
Cemetery or ~~crematory~~: Rest Haven
Location: Hagerstown, Md.

18. Funeral director: A. K. Coffman
Address: Hagerstown, Md.

19. 12/3/47 19____ (Date rec'd by registrar) J. M. Keller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 1 1947, at 6.30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 1 1947 to Dec 1 1947
and that I last saw her alive on Dec 1 1947

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to: Pulmonary Edema	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. M. Thatcher, M.D. M. D. or other
Address: Hancock, Md. Date signed: 12/2/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

11640

CERTIFICATE OF DEATH

Reg. Diat. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, Institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Rural Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: R. D. 6

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Susan Alice Heckman

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: David Heckman

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): October 16, 1880

8. AGE: Years: 67 | Months: 2 | Days: 0 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Franklin Co., Pa.
(Town, county, and state)

10. Usual occupation: Home duties

11. Industry or business:

FATHER
12. Name: John Stoner
13. Birthplace: Franklin Co., Pa.

MOTHER
14. Maiden name: Susan Chase
15. Birthplace: -------- Maryland.

16. Informant: David Heckman
Address: Hagerstown, Md. R D 6

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 19 47 (month) (day) (year)

Cemetery or crematory: Maple Grove Cemetery

Location: Marion, Pa.

18. Funeral director: A. E. Minnich

Address: Greencastle, Pa.

19. Dec. 17. 19 47 (Date rec'd by registrar) Ethel H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 16, 1947 at 4:50 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov. 12 1946 to Dec. 16 1947 and that I last saw her alive on Dec. 16 1947

Immediate cause of death	DURATION
CEREBROL HEMORRHAGE	3days-
Due to Hypertensive cardiovascular renal disease	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.: None

Autopsy results: None.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Archie Robert Cohen M. D. or coroner

Address: Clear Spring Md. Date signed: 12-17-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

11641

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

630

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 weeks

Hospital, institution, or street address where death occurred:

215 West Wilson Blvd.

How long in hospital or institution? at Home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Pennsylvania County: Franklin

City or town: Shippensburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 304 W. King Street

(If rural, give LOCATION)

2.(a) If veteran, name war: No. ✓

3.(a) FULL NAME: Mary Alice Houpt.

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: William Seth Houpt.

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): September - 25 - 1872

8. AGE: Years	Months	Days	If less than one day
75	2	23	..... hrs. ..... min.

9. Birthplace: Fayetteville Franklin Co. Pa.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Calvin P. Carmacks.
13. Birthplace: McConnellsburg, Penna.

MOTHER
14. Maiden name: no Record
15. Birthplace: no Record.

16. Informant: Mrs. Myrtle Mowers

Address: 215 - W. Wilson Blvd. Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 21. 1947 (month) (day) (year)

Cemetery or crematory: Fairview Cemetery

Location: Mercersburg Penna.

18. Funeral director: Wm. J. Hart & Sons

Address: Boonsboro Md.

19. Dec. 19. 1947 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 18th 1947 at 1 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 25 1947, to Dec 18 1947

and that I last saw h... alive on Dec 18 1947

Immediate cause of death	DURATION
Toxic adenoma - Thyroid Gland	4 mo.
Due to	
Due to	
Other conditions: Hemorrhage into Thyroid Gland	2 days

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... injured at work?

23. SIGNATURE: Mary J. McLennan MD M. D. or other

Address: 1594 Washington St Date signed: 12/19/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

830

11642

Reg. Diat. No. 305

Dr Wade

W

1. PLACE OF DEATH:

County: Washington

City or town: Boonsboro

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life.

Hospital, Institution, or street address where death occurred:

S. Main St.

How long in hospital or institution? at Home.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Boonsboro

(If outside city or town limits, write RURAL and give nearest town)

Street No.: S. Main St.

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Harvey J. Huffer

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Janey Huffer

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): October 11, 1863

8. AGE:

Years	Months	Days	If less than one day
84	1	29	..... hrs. ..... min.

9. Birthplace: Near Boonsboro Wash. Co. Md.

(Town, county, and state)

10. Usual occupation: Retired Farmer

11. Industry or business:

FATHER

12. Name: Alfred C. Huffer

13. Birthplace: Wash. Co. Md.

MOTHER

14. Maiden name: Sarah Toms

15. Birthplace: Wash. Co. Md.

16. Informant: Mrs. Janey Huffer

Address: Boonsboro Md.

17. Burial - (Burial, cremation, or removal. Which?) Date thereof: Dec. 13, 1947 (month) (day) (year)

Cemetery or crematory: Boonsboro Cemetery

Location: Boonsboro Md.

18. Funeral director: Wm J. Bast & Sons

Address: Boonsboro Md

19. Dec. 13 1947 John H. Bast

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 10th 1947 at 6.15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10th 1947 to Dec 10th 1947 and that I last saw him alive on Nov 17th 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	6 hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. Hubert Baker M.D.

M. D. or other

Address: Boonsboro Md. Date signed: 12/11/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

I

T

11643

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

CERTIFICATE OF DEATH

Reg. Diat. No. 303

1. PLACE OF DEATH:

County: Washington

City or town: Rural Clear Spring, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 65 years

Hospital, institution, or street address where death occurred:
Residence Route 40

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Rural Clear Spring, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Route 40
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Anna Virginia Hull

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: James E. Hull

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 5, 1868

8. AGE:

Years	Months	Days	If less than one day
79	3	20	hrs. min.

9. Birthplace: Washington County, Md.
(Town, county, and state)

10. Usual occupation: Home Duties

11. Industry or business

FATHER
12. Name: Henry Hull
13. Birthplace: Washington County, Md.

MOTHER
14. Maiden name: Maria Dennis
15. Birthplace: Washington County, Md.

16. Informant: James E. Hull
Address: Clear Spring, Md. R D

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 28, 1947 (month) (day) (year)

Cemetery or crematory: St. Paul's Cemetery

Location: Route 40 Near Spicklers

18. Funeral director: Snyder-Rowland Funeral Home

Address: Clear Spring, Md.

19. Dec 28 1947 (Date rec'd by registrar) Joseph W. Murray Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 25, 1947 at P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 1941 to Dec 25, 1947 and that last saw h alive on Dec 25, 1947

Immediate cause of death	DURATION
(a) Cerebral Sclerosis	4 yrs.
Due to (b) Arteria Sclerosis	10 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: David R. Brewer M.D.
M. D. or other

Address: Clear Spring Md. Date signed: 12/29/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61 11644

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1day

Hospital, Institution, or street address where death occurred: 43 S. Franklin St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Rural--Keedysville, Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Rosa May Jamison

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John W. Jamison

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 19, 1879

8. AGE: Years	Months	Days	If less than one day
68	7	3	hrs. min.

9. Birthplace: Antietam--Wash.--Md (Town, county, and state)

10. Usual occupation: Home Duties

11. Industry or business

FATHER — 12. Name: William Thomas

FATHER — 13. Birthplace: Scotland

MOTHER — 14. Maiden name: Anna Holmes

MOTHER — 15. Birthplace: Virginia

16. Informant: Mr. John W. Jamison

Address: Keedysville, Md R.F. D.

17. Bruial (Burial, cremation, or removal. Which?) Date thereof: Dec. 24 1947 (month) (day) (year)

Cemetery or crematory: Samples-Manor

Location: Dargon--Md

18. Funeral director: R. I. Earnshaw

Address: Keedysville, Md

19. Dec. 23. 1947 (Date rec'd by registrar) Chas. H. Rowerd, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 22 19 47 at 7:30P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 19 45 to Dec 22 19 47 and that I last saw h.e alive on Dec. 22 19 47

Immediate cause of death	DURATION
Chronic Myocarditis	10 yrs
Due to: Diabetes Mellitus	10 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C. W. Kelly M.D. M. D. or other

Address: Boonsboro, Date signed: 12/23/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11645

160

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6½ hours

Hospital, institution, or street address where death occurred: Washington County Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown Rfd.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Pangborn Blvd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Robert Lee Jones

3.(b) Social Security Number: -----

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 2, 1947

8. AGE: Years | Months | Days | If less than one day: 6 hrs. 30 min.

9. Birthplace: Hagerstown Wash. Md.

(Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER

12. Name: Andrew Jones

13. Birthplace: Hagerstown Md.

MOTHER

14. Maiden name: Josephine E. Stouffer

15. Birthplace: Hagerstown Md.

16. Informant: Andrew Jones

Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-3-47 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown Md.

16. Funeral director: Scott F. Minnich & Son

Address: Hagerstown Md.

19. Dec 3, 1947 (Date rec'd by registrar) C. Scott Bowers, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 3 1947 at 4 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 2 Dec 1947, to 3 Dec 1947

and that I last saw him alive on 2 Dec 1947

	DURATION
Immediate cause of death: Birth injury to brain	6 hr.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: F. F. Fusby M. D. or other

Address: 230 N Potomac Date signed: 3 Dec 47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932 11646

Reg. Diat. No. 203

1. PLACE OF DEATH:

County: Washington

City or town: Wilson, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, institution, or street address where death occurred:
Gateway Nursing Home

How long in hospital or institution? 16 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: St. James
(If outside city or town limits, write RURAL and give nearest town)

Street No.: None
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Katherine K. Keller

3.(b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: David F. Keller

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): October 3, 1869

8. AGE: Years	Months	Days	If less than one day
78	2	19	____ hrs. ____ min.

9. Birthplace: Franklin County, Pa.
(Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business

FATHER 12. Name: Jacob Brindle

13. Birthplace: Franklin County, Pa.

MOTHER 14. Maiden name: Elizabeth Gelwicks

15. Birthplace: Franklin County, Pa.

16. Informant: Neslie R. Keller

Address: St. James, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12-24-47 (month) (day) (year)

Cemetery or crematory: St. Thomas Cemetery

Location: St/ Thomas, Pa.

18. Funeral director: Sellers Funeral Home

Address: Chambersburg, Pa.

19. 12-23-47 19____ (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 22 1947 at 1900 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1947 to Dec 22 1947 and that I last saw h[illegible] alive on December 20 1947

Immediate cause of death	DURATION
Cerebral haemorrhage	2 days
Due to: Hypertension Cardio-Vascular disease	(?) Years
Due to:	
Other conditions: Undetermined Obstruction	1 day

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: [signature] Mgr. M. D. or other

Address: Hagerstown Md Date signed: 22 Dec 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

11647

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Dr. Eral Young

CERTIFICATE OF DEATH

830

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 Days

Hospital, institution, or street address where death occurred:

Washington Coty. Hospital

How long in hospital or institution? 4 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give neareat town)

Street No. 813 Dale Street

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: Mrs Geneva King

3.(b) Social Security Number: No

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 7.1861

8. AGE: Years	Months	Days	If less than one day
86	9	14	hrs. min.

9. Birthplace: Sommerset Pa. (Town, county, and state)

10. Usual occupation: House Work

11. Industry or business: Own Home

FATHER 12. Name: Joseph Lichty

13. Birthplace: Dublin, Ireland.

MOTHER 14. Maiden name: Martha Rowan

15. Birthplace: Dublin, Ireland

16. Informant: Mrs Maud Frye

Address: Confluence, Penna.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 24, 1947 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown, Maryland

18. Funeral director: Andrew K. Coffman

Address: Hagerstown, Md

19. Dec 23. 1947 (Date rec'd by registrar) Chas H Howard Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12/21/47 19..., at ... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/16/47 19... to 12/21/47 19...

and that I last saw h... alive on 12/21/47 19...

Immediate cause of death: Cerebral Hemorrhage — DURATION: 5 Days

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Eral Young MD M. D. or other

Address: Hagerstown Md Date signed: 12/22/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

55+ 11648

Reg. Diat. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 52 years

Hospital, institution, or street address where death occurred:
326 South Potomac Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 326 South Potomac Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mary Annette Kiracofe

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: William O. Kiracofe

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 7, 1880

8. AGE: Years	Months	Days	If less than one day
67	10	12	hrs. min.

9. Birthplace: Overal, Virginia
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER
12. Name: Edward H. Kidwell
13. Birthplace: Virginia

MOTHER
14. Maiden name: Harriet S. Harold
15. Birthplace: Virginia

16. Informant: Miss Josephine Kiracofe
Address: Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-22-47 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown, Maryland

18. Funeral director: C. M. Suter & Sons

Address: Hagerstown, Maryland

19. Dec. 21, 1947 (Date rec'd by registrar) Chas. H. Rowland Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 19 1947, at 11 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1947, to Dec. 19 1947 and that I last saw her alive on Dec. 19 1947

Immediate cause of death	DURATION
Multiple myeloma	1 yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: NO Date of op.

Autopsy results: NO

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury: Injured at work?

23. SIGNATURE: Lloyd A. Hoffman M. D. or other

Address: 114 N. Potomac Date signed: Dec. 20. 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11643

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington County

City or town: Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, institution, or street address where death occurred:
Washington County Hospital

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 935 Hamilton Boulevard
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Ross F. Kountz

3. (b) Social Security Number: 705-10-7379

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Anna H. Kountz

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 21, 1876

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
71	5	10		

9. Birthplace: Pittsburgh, Pa.
(Town, county, and state)

10. Usual occupation: Retired Railroad Clerk

11. Industry or business:

FATHER — 12. Name: Benjamin Kountz

FATHER — 13. Birthplace: Chambersburg, Pa.

MOTHER — 14. Maiden name: Emma Henneberger

MOTHER — 15. Birthplace: Chambersburg, Pa.

16. Informant: Dorothy Kountz

Address: Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-3-48 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown, Maryland

18. Funeral director: C. M. Suter & Son

Address: Hagerstown, Maryland

19. Jan. 3, 1948 (Date rec'd by registrar) Chas. F. Boaert, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 31, 1947, at 11 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 30, 1947, to Dec 31, 1947, and that I last saw him alive on Dec 31, 1947.

	DURATION
Immediate cause of death: Cerebral Hemorrhage	12/30/47
Due to: Arteriosclerosis	?
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: H L Porterfield M.D.
M. D. or other

Address: 136 W Washington Date signed: 1/2/48

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11650

932

CERTIFICATE OF DEATH

Reg. Diat. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45 years
Hospital, institution, or street address where death occurred: Washington County Hospital
How long in hospital or institution? 6 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 860 Frederick St.
(If rural, give LOCATION)
2.(a) If veteran, name war: -------

3.(a) FULL NAME: Mary E. Linebaugh

3.(b) Social Security Number: --------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Robert L. Linebaugh
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): February 25, 1903

8. AGE: Years	Months	Days	If less than one day
44	9	25	..... hrs. ..... min.

9. Birthplace: Hagerstown Washington Md.
(Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business: Own Home

FATHER
12. Name: Edward Semler
13. Birthplace: Hagerstown Md.

MOTHER
14. Maiden name: Winifred Kegan
15. Birthplace: Ireland

16. Informant: Robert L. Linebaugh
Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1947-12-23 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown Md.

18. Funeral director: Scott F. Minnich & Son
Address: Hagerstown Md.

19. Dec. 22, 1947 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: ~~February~~ December 20 19 47 at 9 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-20-47 19 to 12-20-47 19
and that I last saw her alive on 12/20/47 19

Immediate cause of death	DURATION
Cerebral Hemorrhage	6 hrs
Due to	
Due to Hypertensive Heart Disease	6 mos
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Chas. Young M.D. M. D. or other
Address: Hagerstown Md. Date signed 12/22/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

11651

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

5184 306

Reg. Dist. No. 144

1. PLACE OF DEATH:
County Washington Co.
City or town (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Fitchie Hospital
How long in hospital or institution? 2.5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Glenndale P.O. Box 75
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war Not known

3.(a) FULL NAME Carroll N. Lockard

3.(b) Social Security Number 220-09-6156

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Amelia J.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 26, 1875

8. AGE: Years	Months	Days	If less than one day
72	6	23	..... hrs. ..... min.

9. Birthplace Westminster, Carroll Co. Md. (Town, county, and state)
10. Usual occupation Salesman
11. Industry or business Insurance
FATHER 12. Name James H. Lockard
FATHER 13. Birthplace Westminster, Md.
MOTHER 14. Maiden name Amanda Taylor
MOTHER 15. Birthplace Westminster
16. Informant Deceased
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 22, 1947 (month) (day) (year)
Cemetery or crematory Westminster Cemetery
Location Westminster Md.
18. Funeral director Wm. Burrupsaw & Son
Address Westminster Md.
19. Dec. 20 1947 (Date rec'd by registrar) 12/24/47 Blanche S. Eyler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 19, 1947, at 3:50 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 24 1947, to Dec. 19 1947 and that I last saw h alive on Dec. 19 1947

Immediate cause of death	DURATION
(a) Acute Circulatory Failure	
Due to (b) Generalized Arteriosclerosis	2 mo.
Due to (c) Carcinoma of prostate	12 mo.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. C. M. Colleran M.D. M. D. or other
Address Fitchie Hosp. Date signed 12/19/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Knoisley
148

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

11652

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 weeks
Hospital, institution, or street address where death occurred: Garloch Nursing home
How long in hospital or institution? 3 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Pa. County: Franklin
City or town: Waynesboro
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 276 E. Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Laura Alice Martin

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	W.

6.(b) Name of husband or wife: Johnson B. Martin
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): April 10, 1864

8. AGE:

Years	Months	Days	If less than one day
83	8	15	..... hrs. ..... min.

9. Birthplace: Near Greencastle Pa.
(Town, county, and state)
10. Usual occupation: House Duties
11. Industry or business:

FATHER
12. Name: Samuel Bartle
13. Birthplace: Antrim Twsp Pa

MOTHER
14. Maiden name: Magdalina Lenhart
15. Birthplace: Antrim Twsp. Pa.

16. Informant: Mrs. Lydia Stoner
Address: Waynesboro Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 28, 1947 (month) (day) (year)
Cemetery or crematory: Green Hill
Location: Waynesboro Pa.
18. Funeral director: Walter L. Grove
Address: 278. Church St. Waynesboro Pa.

19. Dec. 26 1947 (Date rec'd by registrar) Chas. H. Bowers, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 25 1947, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 18 1947 to Dec. 25 1947 and that I last saw h...er...alive on Dec. 20, 1947

Immediate cause of death	DURATION
Cerebral Hemmorrhage	1yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ..... Injured at work?

23. SIGNATURE: B. B. Martin M. D. or other
Address: 148 W. Washington Street Date signed: 211

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

11653

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46 dx

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

25 North Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 25 North Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: James W. McKee

3.(b) Social Security Number: 214-09-1622

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Dora M. McKee

6.(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): May 8, 1880

8. AGE: Years	Months	Days	If less than one day
67	7	19	hrs. min.

9. Birthplace: Hagerstown, Wash. Co. Md.

(Town, county, and state)

10. Usual occupation: Retired Clerk

11. Industry or business

FATHER — 12. Name: William C. McKee

13. Birthplace: Hagerstown, Maryland

MOTHER — 14. Maiden name: Emma C. Middlekauff

15. Birthplace: Hagerstown, Maryland

16. Informant: William McKee

Address: Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-29-47 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown, Maryland

18. Funeral director: C. M Suter & Sons

Address: Hagerstown, Maryland

19. Dec. 29, 1947 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 27 1947 at 6 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 17 1946 to Dec 27 1947 and that I last saw h... alive on Dec 27 1947

Immediate cause of death	DURATION
Carcinoma Rectum	
Metastasis to Bone	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma Rectum

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. L. Porterfield M.D.

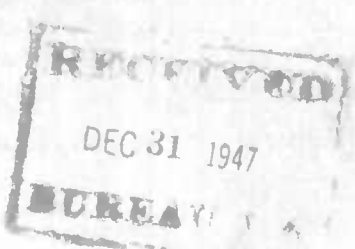
M. D. or other

Address: 136 W Washington Date signed: 12/29/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


DEC 31 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11654

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Rural Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 65 years
Hospital, Institution, or street address where death occurred: Hagerst own Rt.5
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Rural Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Hagerstown Rt. 5
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: C. Stanley Miller

3.(b) Social Security Number: --------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 30, 1882

8. AGE: Years	Months	Days	If less than one day
65	6	26	hrs. min.

9. Birthplace: Hagerstown Rt. 5 Wash. Md.
(Town, county, and state)
10. Usual occupation: Laboror
11. Industry or business: Farm

FATHER
12. Name: Christian D. Miller
13. Birthplace: Hagerstown Rt. 5

MOTHER
14. Maiden name: Ann Daughtry
15. Birthplace: Hagerstown Rt.5

16. Informant: Mr. Warphy Miller
Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1947-12-29 (month) (day) (year)
Cemetery or crematory: Rest Haven Cemetery
Location: Scott F. Minnich & Son

18. Funeral director: Hagerstown Md.
Address:

19. Dec 29, 1947 (Date rec'd by registrar) C. Kent Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 26 1947, at 6:45p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 22 1943, to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary occlusion	1943
Acute Coronary occlusion	12/26/47
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: L. Robert Wells DEPUTY MEDICAL EXAM. WASH. CO. MD.
M. D. or Phys.
Address: Hagerstown, Md. Date signed 12/27/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Dr. Wade.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The street age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

11655

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH:

County: Washington

City or town: Boonsboro

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months.

Hospital, institution, or street address where death occurred:

Guilford Convalescent Home

How long in hospital or institution? 3 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Frederick

City or town: Lanty

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: No ✓

3. (a) FULL NAME: Jessie Key Miller

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Hiram L. Miller

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): November - 17 - 1872

8. AGE:

Years	Months	Days	If less than one day
75	1	0	..... hrs. ..... min.

9. Birthplace: Lanty Frd. Co. Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: Frederick N. Wilhide

13. Birthplace: Lanty Frd. Co. Md.

MOTHER

14. Maiden name: Mary C. Stull

15. Birthplace: Thurmont Frd. Co. Md.

16. Informant: Ralph Miller

Address: Lanty Frd. Co. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 20. 1947 (month) (day) (year)

Cemetery or crematory: United Brethren Cemetery

Location: Thurmont Md.

18. Funeral director: M. L. Creager & Son

Address: Thurmont Md.

19. Dec. 18. 1947 (Date rec'd by registrar) John H. Bart Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 17" 1947 at 8.30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 26 1947, to Dec. 17" 1947

and that I last saw h... alive on Dec. 17" 1947

Immediate cause of death: Senile Dementia. — DURATION: 23 days

Due to: Cerebral Hemorrhage

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. Hubert Bader M. D.

M. D. or other

Address: Boonsboro Md. Date signed: 12/18/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

77c 11656

CERTIFICATE OF DEATH

Reg. Diat. No. 304

1. PLACE OF DEATH:
County Washington
City or town Rural - Hancock
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, Institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Big Pool
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Vernon Thomas Mills

3.(b) Social Security Number 220-10-3079

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of ~~husband~~ or wife Blanche Victoria Shoemaker Mills 6.(c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) June 26, 1893

8. AGE: Years	Months	Days	If less than one day
54	5	10	— hrs. — min.

9. Birthplace Big Pool, Wash. Co., Md. (Town, county, and state)

10. Usual occupation Machine Shop Worker

11. Industry or business

FATHER 12. Name John Henry Mills

13. Birthplace Big Pool, Md.

MOTHER 14. Maiden name Ella Bridendolph

15. Birthplace Big Pool, Md.

18. Informant Mrs. Blanche Mills

Address Big Pool, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 9, 1947 (month) (day) (year)

Cemetery or ~~crematory~~ Dunkard Church

Location near Hancock, Md.

18. Funeral director Charles R. Bast

Address Hancock Md

19. 12/9 19 47 (Date rec'd by registrar) J. M. Stiller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec/6/47 19 about at 8:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ... to ... 19 ... and that I last saw h... alive on ... 19 ...

Immediate cause of death	DURATION
cause to be sent later	
Due to after analysis of organs	
Due to Acute alcoholic narcosis (1/20/48 alha)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results Dec/7/47

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE L Robt Wells DEPUTY MEDICAL EXAM. WASH. CO., MD. M. D. or other

Address Hagerstown, Md. Date signed Dec 8 '47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

11657

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

CERTIFICATE OF DEATH

Reg. Diat. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:
216 Jefferson Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 216 Jefferson Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Emma C. Miner

3.(b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Charles E. Miner

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): November 21, 1884

8. AGE:

Years	Months	Days	If less than one day
63	1	3	....hrs. ....min.

9. Birthplace: Hagerstown, Wash. Co. Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: Gottlieb Langenstein

13. Birthplace: Germany

MOTHER

14. Maiden name: Christine Freger

15. Birthplace: Germany

16. Informant: Charles E. Miner

Address: Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-26-47 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown, Maryland

18. Funeral director: C. M. Suter & Sons

Address: Hagerstown, Maryland

19. Dec 24, 1947 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 24 1947, at 2 30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1 1947, to 12/23 1947 and that I last saw h.er alive on 12/23 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 Weeks
Due to: arteriosclerosis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: ....Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Vita Z Miller. M. D. or other

Address: Hagerstown Date signed 12/24 1947

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Dr Vic Miller

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

928 11658

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 years

Hospital, institution, or street address where death occurred:

Washington County Home

How long in hospital or institution? 12 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Washington County Home

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: James Emory Moore

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 10, 1867

8. AGE: Years	Months	Days	If less than one day
80	4	29	hrs. min.

9. Birthplace: Brunswick, Maryland (Town, county, and state)

10. Usual occupation: Attendant

11. Industry or business: Washington Co. Home

FATHER

12. Name: James Moore

13. Birthplace: Maryland

MOTHER

14. Maiden name: Anna Myers

15. Birthplace: Maryland

16. Informant: Mary B. Jenkins

Address: 1103 Fry Ave. Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 11, 1947 (month) (day) (year)

Cemetery or crematory: Samples Manor Cemetery

Location: Pleasantville, Md.

18. Funeral director: Fred W. Kraiss

Address: Hagerstown, Md.

19. Dec. 11, 1947 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 9th 1947, at 12 45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1st 1947, to Dec 9th 1947, and that I last saw him alive on Dec 6 1947

Immediate cause of death	DURATION
Coronary Occlusion	9 days
Due to: Mitral Stenosis	3 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Ernest F Poole M.D. M. D. or other

Address: Hagerstown Md Date signed: 12/10/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The most exact age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45.15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

11659

Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:
1140 The Terrace

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1140 The Terrace
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: LeNora G. Mumma

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Allen H. Mumma

6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): April 28, 1880

8. AGE: Years	Months	Days	If less than one day
67	7	22	...hrs. ...min.

9. Birthplace: Hagerstown, Wash. Co. Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Owen Geary
13. Birthplace: Ireland

MOTHER
14. Maiden name: Catherine Sullivan
15. Birthplace: Ireland

16. Informant: Allen H. Mumma
Address: Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-23-47 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown, Maryland

18. Funeral director: C. M. Suter & Sons
Address: Hagerstown, Maryland

19. Dec. 23 1947 (Date rec'd by registrar) Elizabeth Bowers, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 20 1947 at 2 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1947 to Dec 20 1947 and that I last saw h... alive on Dec. 20 1947

Immediate cause of death	DURATION
Cerebral hemorrhage	Immediate
Due to Hypertensive cardio vascular disease	years
Due to Arterio sclerosis	years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: No

Date of op.

Autopsy results: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Chas. A. Hoffman, M. D. or other

Address: 214 N. Potomac St. Date signed: Dec. 20-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46 ct 11660

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Gaslock Memorial Nursing Home
How long in hospital or institution? 5 wks.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md County: Washington
City or town: Rural (Ringgold) (If outside city or town limits, write RURAL and give nearest town)
Street No.: Hagerstown #5 (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Emma B. Newcomer
3. (b) Social Security Number:

4. Sex: Female
5. Color or race: W.
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife:
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Dec. 9 1867

8. AGE: Years: 80 Months: 0 Days: 5 If less than one day: ... hrs. ... min.

9. Birthplace: Ringgold Md. (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business:

FATHER
12. Name: Benjamin Newcomer
13. Birthplace: Ringgold Md.

MOTHER
14. Maiden name: Mary M. Garver
15. Birthplace: Ringgold Md.

16. Informant: Miss Zella Newcomer
Address: 302 N. Potomac St. Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12/13/47 (month) (day) (year)
Cemetery or crematory: Green Hill Cemetery
Location: Waynesboro #3, Waynesboro, Pa.
18. Funeral director: Walter Y. Green
Address: 27 S. Church St. Waynesboro, Pa.
19. Dec. 11, 1947 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 10 1947, at 6 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 4 1947, to Dec. 10, 1947 and that I last saw her alive on Dec 10 1947

	DURATION
Immediate cause of death: Carcinomatosis	3 wks
Due to: [illegible] carcinoma of sigmoid	2 yr
Due to: —	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.
Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury
Injured at work?

23. SIGNATURE: G. A. Kohler M. D. or other
Address: Smithsburg Date signed: 12/11/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

11661

Reg. Diat. No. 306

1. PLACE OF DEATH:
County: Washington
City or town: Rural Smithsburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Washington
City or town: Rural Smithsburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. Smithsburg # 2 Md
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Nannie Elizabeth Newcomer

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Cyrus Newcomer
6.(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): Oct. 13, 1873

8. AGE: Years	Months	Days	If less than one day
74	1	19	hrs. min.

9. Birthplace: Smithsburg (Town, county, and state)
10. Usual occupation: House wife
11. Industry or business

FATHER
12. Name: William F. Riderenour
13. Birthplace: Smithsburg Md

MOTHER
14. Maiden name: Elizabeth Ann Hetherington
15. Birthplace: Washington Co. Md

16. Informant: Cyrus Newcomer
Address: Smithsburg Md #2

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/15/47 (month) (day) (year)
Cemetery or crematory: Smithsburg cemetary
Location: Smithsburg Md

18. Funeral director: Walter H. Keefer
Address: 27 E. Church St. Waynesboro, Pa.

19. Rec'd 13 1947 (Date rec'd by registrar) Geo. W. Ferguson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 12 1947 at 7 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 12 1947 to Dec 12 1947 and that I last saw h.. alive on Dec 12 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	5 hrs
Due to: Cirrhosis	10 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: W. G. Keefer M. D. or other
Address: Smithsburg Date signed: 12/13/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

11662

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Washington Co. Hospital
How long in hospital or institution? 45 Minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 218 Potomac St
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William E. Petrie

3.(b) Social Security Number 214-14-6484

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Divorced

6.(b) Name of husband or wife Catherine Smith
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Mar. 25th 1886

8. AGE: Years 61 Months 8 Days 21 If less than one day ..... hrs. ..... min.

9. Birthplace Washington Co. Md
(Town, county, and state)

10. Usual occupation Pipe Finisher

11. Industry or business Pipe Organ Works.

FATHER 12. Name John W. Petrie
13. Birthplace Washington Co. Md

MOTHER 14. Maiden name Margaret L. Cross
15. Birthplace Washington Co. Md.

16. Informant Mrs Roy S. Longo
Address 125 Jonathan Court Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/18/47 (month) (day) (year)

Cemetery or crematory Rest Haven Cemetery
Location Hagerstown Md.

18. Funeral director L. F. Beecher
Address Funkstown Md.

19. Dec. 17, 1947 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION 10:05

20. DATE OF DEATH Dec/15/47 19..... at P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death ..... DURATION
acute coronary occlusion
Due to .....
Due to .....
Other conditions .....
(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....
Autopsy results no
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide No Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE J. Robert Mills M. D.
DEPUTY MEDICAL EXAM. WASH. CO., MD.
Address Hagerstown, Md. Date signed 12/17/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11663

932

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 years

Hospital, institution, or street address where death occurred:

339 South Potomac Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 339 South Potomac Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: S. Katherine Pugh

3.(b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: S. Huber Pugh

6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): April 10, 1877

8. AGE: Years	Months	Days	If less than one day
70	8	17	....hrs. ....min.

9. Birthplace: Chambersburg, Pa. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: John Heckman

13. Birthplace: Stroudsburg, Pa.

MOTHER — 14. Maiden name: Martha Long

15. Birthplace: Greenscastle, Pa.

16. Informant: S. Huber Pugh

Address: Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12-29-47 (month) (day) (year)

Cemetery or crematory: Greenhill Cemetery

Location: Greenscastle, Pa.

18. Funeral director: C. M. Suter & Sons

Address: Hagerstown, Maryland

19. Dec. 29, 1947 (Date rec'd by registrar) Chas. H. Beverd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 27 Dec 1947 at 4:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1940 to 27 Dec 1947 and that I last saw h.. alive on 27 Dec 1947

Immediate cause of death	DURATION
Asteriosclerotic Cardiac Vascular Disease	15yrs +
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ..... Injured at work?

23. SIGNATURE: F. F. Lusby M. D. or other

Address: 230 N Potomac St Date signed: 29 Dec 47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131 b

11664

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 Days

Hospital, Institution, or street address where death occurred:

Washington Co. Hospital

How long in hospital or institution? 10 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Funkstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Ridenour, Carl A.

3.(b) Social Security Number: 705-10-5393

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Verda K. Hinkle

6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): May 5th 1893

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
54	7	1		

9. Birthplace: Washington Co. Md. (Town, county, and state)

10. Usual occupation: Freight Conductor

11. Industry or business: Western Maryland R.R.

FATHER — 12. Name: William H. Ridenour

FATHER — 13. Birthplace: Washington Co. Md.

MOTHER — 14. Maiden name: Marie E. Brezler

MOTHER — 15. Birthplace: Washington Co Md.

16. Informant: Verda K Ridenour

Address: Funkstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12/9/47 (month) (day) (year)

Cemetery or crematory: Rest Haven Cemetery

Location: Hagerstown Md.

18. Funeral director: L. H. Beecher

Address: Funkstown, Md.

19. Dec. 9. 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 6, 1947 at 7 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 24 1947, to December 6 1947

and that I last saw h... alive on December 6, 1947

Immediate cause of death: Chronic nephritis — DURATION: 6 mos.

Due to:

Due to:

Other conditions: Chronic nephritis — DURATION: 7 mos.

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: None. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: R. Lawrence MD M. D. or other

Address: Hagerstown, Md Date signed 12/8/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

11665

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 64 years

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 828 Georgia Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mary E. Ridenour

3.(b) Social Security Number: None

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Nathan Ridenour

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 14, 1863

8. AGE: Years: 84 | Months: 1 | Days: 0 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Hagerstown-Washington-Md (Town, county, and state)

10. Usual occupation: Home Duties

11. Industry or business:

FATHER — 12. Name: Unknown

13. Birthplace: "

MOTHER — 14. Maiden name: "

15. Birthplace: "

16. Informant: Mr. Carl Ridenour

Address: 535-5th. St. S. E. - Wash. D. C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 16, 1947 (month) (day) (year)

Cemetery or crematory: Manor

Location: Tilghmanton, Md

18. Funeral director: R. I. Earnshaw

Address: Keedysville, Md

19. Dec 16. 1947 (Date rec'd by registrar) Chas. H. Rowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 14 19 47 at 7:50 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 2 19 47 to Dec 14 19 47 and that I last saw h.. alive on December 13 19 47

	DURATION
Immediate cause of death: Congestive Heart Failure.	12 days
Due to: Hypertension cardio-vascular disease	
Due to:	
Other conditions: Pneumonia Lingular	10 days.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W. J. Layman M.D.

Address: Hagerstown Md. M. D. or other

Date signed: Dec 15th 1947

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr Lusby

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

Dr. Lusby

11666

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 Days

Hospital, Institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution? 4 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 816 Maryland Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: PAUL LEROY RIDER

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: --

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): December 3, 1947

8. AGE: Years	Months	Days	If less than one day
0	0	4	..... hrs. ..... min.

9. Birthplace: Hagerstown Washington Co. Md. (Town, county, and state)

10. Usual occupation: --

11. Industry or business: --

FATHER — 12. Name: John Howard Rider

13. Birthplace: Hagerstown Md.

MOTHER — 14. Maiden name: Zelda Geraldine Constable

15. Birthplace: Warderville W. Va.

16. Informant: John H. Rider

Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/8/47 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown Md.

18. Funeral director: Andrew K. Coffman

Address: Hagerstown Md.

19. Dec. 8 1947 Chas. H. Bowers (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 7 1947, at 2 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3 Dec 1947, to 7 Dec 1947 and that I last saw h[illegible] alive on 6 Dec 1947

Immediate cause of death	DURATION
Prematurity (26 weeks)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE: F. F. Lusby M. D. or other

Address: 230 N Potomac Date signed 8 Dec 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

55 4 11667

Reg. Dist. No. 301

1. PLACE OF DEATH:

County: Washington County

City or town: Williamsport Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 32 yrs

Hospital, Institution, or street address where death occurred:
33 West Potomac Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Williamsport Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 33 W. Potomac Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Charles Gary Rohr

3. (b) Social Security Number: 214-09-1219

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Viola B Rohr

6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): Jan 23 1878

8. AGE: Years	Months	Days	If less than one day
69	10	25	hrs. min.

9. Birthplace: Sharpsburg Md.
(Town, county, and state)

10. Usual occupation: Night Watchman

11. Industry or business: W. F. Pryors & Co (Bookbinding)

FATHER
12. Name: Josiah Rohr
13. Birthplace: Boonsboro Md.

MOTHER
14. Maiden name: Lillian Smith
15. Birthplace: Sharpsburg Md.

16. Informant: Mrs. Viola B. Rohr (wife)
Address: 33 W. Potomac Street Williamsport

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 21 1947 (month) (day) (year)

Cemetery or crematory: Rest Haven Cemetery

Location: Hagerstown Md.

18. Funeral director: Edith V. Leaf

Address: 7 Church Street Williamsport Md.

19. 12/21 1947 (Date rec'd by registrar) Mrs. Ethel McElroy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 18 1947 at 2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1 1947 to Dec. 18 1947 and that I last saw him alive on Dec. 18 1947

Immediate cause of death	DURATION
Sarcoma of left leg	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature]

Address: Williamsport Md. M. D. or other

Date signed: 12/20/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11668

131a

Reg. Diat. No. 307

Dr. Le Van

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Washington

City or town: Rohrersville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred: Rohrersville Md.

How long in hospital or institution? at Home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of motber)

State: Maryland County: Washington

City or town: Rohrersville

(If outside city or town limits, write RURAL and give nearest town)

Street No. Rohrersville Md.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Elmer Joseph Samuel Rohrer

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Cora A. Rohrer

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): February - 19 - 1872

8. AGE: Years 75 | Months 9 | Days 27 | If less than one day ..... hrs. ..... min.

9. Birthplace: Rohrersville Wash. Co. Md. (Town, county, and state)

10. Usual occupation: Retired Employee of Co. Road Dept

11. Industry or business

FATHER 12. Name: John V. Rohrer

13. Birthplace: Rohrersville Wash. Co. Md.

MOTHER 14. Maiden name: Sophia Beales

15. Birthplace: Rohrersville Wash. Co. Md.

16. Informant: Mrs. Cora A. Rohrer

Address: Rohrersville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 13. 1947 (month) (day) (year)

Cemetery or crematory: Rohrersville Cemetery

Location: Rohrersville Md.

18. Funeral director: Wm. J. Bast & Sons

Address: Boonsboro Md.

19. Dec 13 1947 (Date rec'd by registrar) Mrs. Katherine Dagenhart Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 10 1947 at 5.20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1945 to Dec. 10 1947

and that I last saw him alive on December 9 1947

Immediate cause of death	DURATION
Cardio-Renal Vascular Disease	6 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: G W Etter M.D

M. D. or other

Address: Boonsboro Date signed 14/12/47

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

63b 11665

Reg. Dist. No. 306

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Washington
City or town: Near Smithsburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 - 6 mo
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Near Smithsburg Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. —none—
(If rural, give LOCATION)
2.(a) If veteran, name war: —none—

3. (a) FULL NAME: Bessie Emma Rudisill

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: none
6.(c) If alive, give age —
7. Birth date of deceased (mo., day, yr.) 2-26-1882

8. AGE: Years	Months	Days	If less than one day
65	2	25	— hrs. — min.

9. Birthplace: Smithsburg md (Town, county, and state)
10. Usual occupation: Home Keeping
11. Industry or business: —

FATHER
12. Name: Adam Hoffman
13. Birthplace: Fairfield Pa

MOTHER
14. Maiden name: Elizabeth Hoffman
15. Birthplace: Fairfield Pa.

16. Informant: Myrtle Rowe
Address: Smithsburg md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-23-1947 (month) (day) (year)
Cemetery or crematory: Rest Haven
Location: Hagerstown md

18. Funeral director: Geo. B. Hoover
Address: Smithsburg md

19. Dec 22 1947 (Date rec'd by registrar) Geo W Ferguson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 21 1947 at 6.30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 19 1947 to Dec 21, 1947 and that I last saw h[illegible] alive on Dec 21 1947

Immediate cause of death	DURATION
Pulmonary embolism	3 day
Due to: Mitral Stenosis	30
Myocarditis +	10
Due to: Coronary sclerosis & Heart	10 day
Other conditions: Hyperthyroidism	10 yr

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: E. C. Keller M. D. or other
Address: Smithsburg Md Date signed 12/22/47

5'2

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

97 11670

Reg. Dist. No. 303

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County: Washington
City or town: Rural Clearspring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Rural Clearspring
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war.

3. (a) FULL NAME: Louise Catherine Salmon

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Harry S. Salmon
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 9, 1873

8. AGE:

Years	Months	Days	If less than one day
74	3	23	..... hrs. ..... min.

9. Birthplace: Washington Co. Md.
(Town, county, and state)
10. Usual occupation: Home duties
11. Industry or business

FATHER
12. Name: Samuel Steele
13. Birthplace: Washington Co. Md.

MOTHER
14. Maiden name: Alberta B. Bottles
15. Birthplace: Washington Co. Md.

16. Informant: Charles E. Salmon
Address: Clearspring, Md. R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 4, 1947 (month) (day) (year)
Cemetery or ~~crematory~~: Park Hill
Location: Park Hill Md
18. Funeral director: Snyder-Rowland
Address: Hancock, Md.

19. Dec 4 1947 (Date rec'd by registrar) Joseph W. Murray Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 2, 1947, at 7 9 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1947, to Dec 2, 1947
and that I last saw him alive on Dec. 2, 1947

Immediate cause of death	DURATION
Cerebral Sclerosis	3 mo.
Due to: Arterio Sclerosis	7 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: David P. Brewer M.D
M. D. or Other
Address: Clear Spring Md Date signed: 12/3/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

940 11671

Reg. Dist. No. 301

1. PLACE OF DEATH:
County Washington County
City or town St. James
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 yrs.
Hospital, Institution, or street address where death occurred:
St. James Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washimgton
City or town St. James
(If outside city or town limits, write RURAL and give nearest town)
Street No. St. James
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mr. Joseph F Sensenbaugh

3.(b) Social Security Number 219-05-2493

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Mary Ellen Sensenbaugh deceased
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 8 1873

8. AGE: Years	Months	Days	If less than one day
74	2	23	..... hrs. ..... min.

9. Birthplace Wolfsville Maryland (Town, county, and state)
10. Usual occupation Clerk (Myron Blooms)
11. Industry or business Grocery Store

FATHER
12. Name Peter Sensenbaugh
13. Birthplace Frederick Co. Md.

MOTHER
14. Maiden name Alinda Katherine Hessong
15. Birthplace Frederick Co. Md.

16. Informant Virginia Sensenbaugh
Address St. James Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 6 1947 (month) (day) (year)
Cemetery or crematory Manor Cemetery
Location Tilghmanton Md.

16. Funeral director Edith V. Leaf
Address #7 Church Street Williamsport Md.

19. Dec 6 19 47 Mrs. E. Lee McElroy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 2 19 47 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-3-46 19 to 12/2/47 19
and that I last saw h... alive on 12/2/47 19

Immediate cause of death	DURATION
Coronary Occlusion	Immediate
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE L. F. Young M. D. or other
Address Williamsport Md Date signed 12/4/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

61 11672

Reg. Dist. No. 304

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County: Washington
City or town: Hancock
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hancock
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Charles Samuel Shives

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 11, 1890

8. AGE: Years 57 | Months 11 | Days 6 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Fulton Co. Pa.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: James Shives
13. Birthplace: Washington Co. Md.

MOTHER
14. Maiden name: Mary A. Moore.
15. Birthplace: Wash. Co. Md.

16. Informant: James W. Shives
Address: Hancock, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 21, 1947 (month) (day) (year)
Cemetery or crematory: Rehobeth Cemetery
Location: 6 miles North Hancock

18. Funeral director: Snyder-Rowland
Address: Hancock, Md.

19. 12/20/47 (Date rec'd by registrar) J. D. Heller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 18, 1947, at 7 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on Dead on arrival 19.....

Immediate cause of death	DURATION
Coronary Embolism	12-18-47
Due to: Arteriosclerosis	
Due to: Diabetes Mellitus	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Herbert R. Zahniser M.D.
M. D. or other
Address: Hancock Md. Date signed: 12-20-47

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Wells

11673

164c

Reg. Dist. No. ~~502~~ 303

1. PLACE OF DEATH:

County Washington

City or town Rural Clearspring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

3 Miles North Of Clearspring

How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Rural Clearspring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3 Miles North of Clearspring

(If rural, give LOCATION)

2.(a) If veteran, name war World War #1

3.(a) FULL NAME SAMUEL SIEBERT

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife --

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) January 16, 1891

8. AGE:

Years	Months	Days	If less than one day
56	10	24	..... hrs. ..... min.

9. Birthplace Clearspring, Washington Co., Md. (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER

12. Name William Siebert

13. Birthplace Clearspring Md.

MOTHER

14. Maiden name Elizabeth Troup

15. Birthplace Mercersburg Pa.

16. Informant Alan Siebert

Address Clearspring Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/12/47 (month) (day) (year)

Cemetery or crematory St. Pauls Cemetery

Location Near Clearspring, Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. Dec 11 1947 (Date rec'd by registrar) Joseph Murray Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 10 19 47 at 12 N M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Gun shot wound of skull	
Due to (avulsion of skull	
and brain tissue)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of Dec/10/47

Where did injury occur? Clearspring (City or town) Wash. (County) Md. (State)

Injured at home, farm, industry, public place (where?) farm Injured at work? field

Means of injury shot self with shotgun

23. SIGNATURE L. Robert Wells DEPUTY MEDICAL EXAM. WASH. CO., MD. M. D.

Address Hagerstown Md Date signed 12/10/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11674

1900

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, institution, or street address where death occurred: Washington County Hospital
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hancock
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Jacob Elmer Sinsel

3.(b) Social Security Number: 214-14-6215

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Rose Izora Shives Sensel
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): June 18, 1877

8. AGE: Years	Months	Days	If less than one day
70	5	17	..... hrs. ..... min.

9. Birthplace: Hancock, Washington Co., Md.
(Town, county, and state)
10. Usual occupation: Retired
11. Industry or business

FATHER
12. Name: Henry Sensel
13. Birthplace: St. James, Md.

MOTHER
14. Maiden name: Ellen Weaver
15. Birthplace: Hancock, Md.

16. Informant: James Sensel
Address: Hancock, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 9, 1947 (month) (day) (year)
Cemetery or crematory: St. Peter&s Catholic Cemetery
Location: Hancock, Md.

18. Funeral director: Charles R. Bast
Address: Hancock, Md.

19. Dec 8. 1947 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec/5/47 19..... at 9:45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Lacerated(rt) lungs, liver,	
Due to rt kidney, hemorrhage	
into rt adrenal gland	
Due to fractured ribs	
Other conditions hemorrhage & shock	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: Dec/6/47 as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of Dec. 2-47
Where did injury occur? Hancock (City or town) Wash. (County) Md. (State)
Injured at home, farm, industry, public place (where?) Street
Means of injury Struck By Auto Injured at work? no

23. SIGNATURE: J. Robert Wells DEPUTY MEDICAL EXAM. WASH. CO., MD. M. D. or
Address: Hagerstown Md. Date signed: Dec. 8 '47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Birth + Death 11675

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF ~~STILLBIRTH~~ 160C

Reg. Dist. No. 3-12

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:
   County Washington
   City or town Hagerstown
   (If outside city or town limits, write RURAL and give nearest town)
   Street address, hospital, or institution: Washington County Hospital
   Length of mother's stay in County 1 1/2 years
   (How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:
   State Maryland
   County Washington
   City or town Hagerstown
   (If outside city or town limits, write RURAL and give nearest town)
   Street No. 602 N Potomac Street
   (If RURAL give LOCATION)

3. Name of child ~~Baby Boy~~ Sloneker
4. Date of birth 12/16 1947 Hour 12:35 A.M.
5. Sex undetermined 6. Twin or triplet Twin
7. No. of weeks pregnancy 26 weeks

FATHER OF CHILD

8. Full name Unknown
9. Color ..... 10. Age at time of this birth ..... yrs.
11. Usual occupation .....

MOTHER OF CHILD

12. Full maiden name Faye Marie Sloneker
13. Color White 14. Age at time of this birth 24 yrs.
15. Usual occupation Stenographer

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? None
    (b) How many other children were born alive but are now dead? 0 (c) How many other children were *born* dead? None

17. Did child die before labor? ..... During labor? .....
18. Pregnancy, complications of .....
19. Labor: (a) Complications of .....
    (b) Induced? .....
20. (a) Was there an operation for delivery? ..... (Yes or No)
    (b) State all operations, if any .....
    (c) Did child die before operation? .....
    During operation? .....

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.
    (a) Fetal causes .....
    (b) Maternal causes Self induced labor

22. I certify to the birth of this child who was born dead* on the date and hour above stated.
    Signature J. Robert Wells M.D.
    (Specify if M. D., midwife, or other)
    Address Hagerstown, Md.

23. (a) ..... (b) Date thereof .....
    (Burial, cremation or removal) (month) (day) (year)
    (c) Cemetery or crematory .....
24. (a) Funeral director .....
    (b) Address .....

25. (a) ..... (b) .....
    (Date rec'd by registrar) (Registrar)

26. (To be filled out if no physician was present at delivery.) The above certificate has been examined by me.
    ..... Health Officer, per .....

V. S. A10

* See Instruction C on stub.

Child lived 1 hour 5 minutes

Birth + Death 11676

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF ~~STILLBIRTH~~ 1600

Reg. Dist. No. 3

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:
   County Washington
   City or town Hagerstown
   (If outside city or town limits, write RURAL and give nearest town)
   Street address, hospital, or institution: Washington County Hospital
   Length of mother's stay in County 1 1/2 years
   (How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:
   State Maryland
   County Washington
   City or town Hagerstown
   (If outside city or town limits, write RURAL and give nearest town)
   Street No. 602 N. Potomac Street
   (If RURAL give LOCATION)

3. Name of child ~~Baby Girl~~ Sloneker
4. Date of birth 12/16 1947 Hour 12:30 M.
5. Sex Undetermined 6. Twin or triplet Twin
7. No. of weeks pregnancy 26 weeks

FATHER OF CHILD

8. Full name Unknown
9. Color ..... 10. Age at time of this birth ..... yrs.
11. Usual occupation .....

MOTHER OF CHILD

12. Full maiden name Faye Marie Sloneker
13. Color White 14. Age at time of this birth 24 yrs.
15. Usual occupation Stenographer

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? None
(b) How many other children were born alive but are now dead? None (c) How many other children were *born* dead? None

17. Did child die before labor? ..... During labor? .....
18. Pregnancy, complications of .....
19. Labor: (a) Complications of .....
(b) Induced? .....
20. (a) Was there an operation for delivery? ..... (Yes or No)
(b) State all operations, if any .....
(c) Did child die before operation? .....
During operation? .....

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.
(a) Fetal causes .....
(b) Maternal causes S/P induced labor

22. I certify to the birth of this child who was born dead* on the date and hour above stated.
Signature S. Robert Wells M.D.
(Specify if M. D., midwife, or other)
Address Hagerstown Md.

23. (a) ..... (Burial, cremation or removal) (b) Date thereof ..... (month) (day) (year)
(c) Cemetery or crematory .....
24. (a) Funeral director .....
(b) Address .....

25. (a) Dec. 20 1947 (Date rec'd by registrar) (b) Chas. H. Howard (Registrar)

26. (To be filled out if no physician was present at delivery.) The above certificate has been examined by me.
..... Health Officer, per .....

Received by mail

V. S. A10

* See Instruction C on stub.

Child L. med 57 min.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11677

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 Days

Hospital, Institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution? 5 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Fredrick

City or town: Sabillasville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Larry Smith

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: ---

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): October 3, 1947

8. AGE:

Years	Months	Days	If less than one day
0	2	2	..... hrs. ..... min.

9. Birthplace: Sabillasville, Fredrick C., Md. (Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER

12. Name: Albert Smith

13. Birthplace: Lantz Md.

MOTHER

14. Maiden name: Ethel Forrest

15. Birthplace: Lantz Md.

16. Informant: Mrs. Ethel Smith

Address: Lantz Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12/7/47 (month) (day) (year)

Cemetery or crematory: Bethel Cemetery

Location: Near Camp Richie Md.

18. Funeral director: Andrew K. Coffman

Address: Hagerstown Md.

19. Dec. 6, 1947 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12/5/1947 at 7:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/30/1947 to 12/5/1947 and that I last saw h... alive on 12/5/1947.

Immediate cause of death	DURATION
Bronchio Pneumonia	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. W. Bowman M.D. M. D. or other

Address: Hagerstown, Md. Date signed: 12-7-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11678

464

Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Washington

City or town Near Fiddlersburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5-42

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Near Fiddlersburg Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war War One

3. (a) FULL NAME Nelson Jay Smith

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife no wife

6.(c) If alive, give age none years

7. Birth date of deceased (mo., day, yr.) 7-1892

8. AGE:

Years	Months	Days	If less than one day
55	8	30	— hrs. — min.

9. Birthplace Pleasant Valley. (Town, county, and state)

10. Usual occupation Laborer.

11. Industry or business "

FATHER

12. Name Emory Smith

13. Birthplace Pleasant Valley.

MOTHER

14. Maiden name Lillie Miller

15. Birthplace Pleasant Valley.

16. Informant Elmer D. Kline

Address Hagerstown md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-3-1948 (month) (day) (year)

Cemetery or crematory Pleasant Valley

Location At Pleasant Valley Churchyard

18. Funeral director Geo. B. Hooder

Address Smithsburg md

19. Jan. 1 1948 (Date rec'd by registrar) Chas H Boevers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 31- 1947, at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1- 46 19..... to Dec 31-47 19.....

and that I last saw alive on Dec 30-47 19.....

Immediate cause of death	DURATION
Carcinoma (Colon)	14 months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE L. W. Stitz M. D. or other

Address Hagerstown Md Date signed 1/6/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11679

122a

CERTIFICATE OF DEATH

Reg. Dist. No. 201

1. PLACE OF DEATH:

County: Washington

City or town: Sharpsburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Sharpsburg
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Gladys Pauline Snavely

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): July 8, 1897

8. AGE: Years	Months	Days	If less than one day
50	5	9	... hrs. ... min.

9. Birthplace: Sharpsburg-Wash.-Md
(Town, county, and state)

10. Usual occupation: Home Duties

11. Industry or business

FATHER
12. Name: Joseph Snavely
13. Birthplace: Eakle's Mill-Wash.-Md

MOTHER
14. Maiden name: Annie Smith
15. Birthplace: Sharpsburg--Md

16. Informant: Mrs. Walter Roulette

Address: Sharpsburg, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 19 1947 (month) (day) (year)

Cemetery or crematory: Mt. View

Location: Sharpsburg, Md

18. Funeral director: R. I. Earnshaw

Address: Keedysville, Md

19. Dec 19 1947 (Date rec'd by registrar) Ell Boyer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 17 1947 at 4:10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 13 1947 to Dec. 17, 1947 and that I last saw her alive on December 16, 1947

Immediate cause of death	DURATION
Intestinal obstruction	3 days
Due to: Strangulated right inguinal hernia	3 days
Due to:	
Other conditions: Pneumonia, Arteriosclerotic heart disease, Mongolism (Include pregnancy within 3 months of death)	6 days, 10 yrs, Life.

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Henry Aldis M. D.
M. D. or Other

Address: Shepherdstown, W. Va. Date signed: Dec

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

11680

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

186a

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 39 years

Hospital, institution, or street address where death occurred:
Washington County Hospital

How long in hospital or institution? 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1237 Potomac Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Emma Sommer

3. (b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Charles Sommer

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): June 24, 1870

8. AGE: Years	Months	Days	If less than one day
77	6	7	..... hrs. ..... min.

9. Birthplace: Leighitz, Germany
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER
12. Name: Johann Feist
13. Birthplace: Germany

MOTHER
14. Maiden name: Not Known Feist
15. Birthplace: Germany

16. Informant: John G. Sommer
Address: Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-2-48 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown, Maryland

18. Funeral director: C. M. Suter & Sons

Address: Hagerstown, Maryland

19. Jan. 2, 1948 (Date rec'd by registrar) Elast H Bowers, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 31 1947, at 6 00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 15 1947 to Dec 31 1947 and that I last saw her alive on Dec 30 1947

Immediate cause of death	DURATION
Fracture R femur	18 days
Due to: had been confined to bed room for 6 months Apparently attempted to arise from bed	
Due to: Chronic	
Other conditions: Paget's disease	10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Unknown Date of 12-13-47

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) Bed room

Means of injury: as above Injured at work?

23. SIGNATURE: Robert P. Conrad M.D. M. D. or other

Address: Hagerstown, Md. Date signed 1-2-48

Attended deceased until death. Robert P. Conrad M.D.

DUPLICATE WASH. CO., MD. MEDICAL EXAM.

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.


RECEIVED
JAN 5 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

82 11681

Reg. Diat. No. 302

1. PLACE OF DEATH:

County: WASHINGTON

City or town: HAGERSTOWN (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 YRS.

Hospital, institution, or street address where death occurred: 652 W. WASHINGTON ST. HOME VOLUNTEERS OF AMERICA

How long in hospital or institution? 10 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: MARYLAND County: WASHINGTON

City or town: HAGERSTOWN (If outside city or town limits, write RURAL and give nearest town)

Street No. 527 S. POTOMAC ST. (If rural, give LOCATION)

2.(a) If veteran, name war: NON-VET.

3.(a) FULL NAME: FANNIE SPANGLER

3.(b) Social Security Number: NONE

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife: C. H. SPANGLER

6.(c) If alive, give age: 83 years

7. Birth date of deceased (mo., day, yr.): NOVEMBER 14, 1883

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
64	0	29		

9. Birthplace: GREENCASTLE, FRANKLIN, PA. (Town, county, and state)

10. Usual occupation: HOUSEWIFE

11. Industry or business

FATHER 12. Name: JAMES WAGNER

13. Birthplace: PA.

MOTHER 14. Maiden name: NANCY KUHN

15. Birthplace: PA.

16. Informant: Alice Wagner

Address: Greencastle, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/16/47 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Greencastle Pa.

18. Funeral director: C. T. Norcent

Address: Hagerstown Md.

19. Dec 15 1947 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 13, 1947 at 4:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 4, 1947 to Dec. 13, 1947 and that I last saw her alive on December 10, 1947

Immediate cause of death: Progressive muscular atrophy — DURATION: 13 years

Due to:

Due to:

Other conditions: None

(Include pregnancy within 3 months of death)

Major findings of operations: No operation Date of op.

Autopsy results: No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R. A. Bell M. D. or other

Address: Hagerstown Md. Date signed 12/15/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Bell
119 N. Potomac St.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1952 11682

Reg. Dist. No. 36-2

1. PLACE OF DEATH:

County Washing, Co.

City or town Hagerstown Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 Days

Hospital, Institution, or street address where death occurred:
Washington Co. Hospital

How long in hospital or institution? 24 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Wash.

City or town Hancock Md. Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Linda May Spriggs

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	Single

6.(b) Name of husband or wife ~~Charles Spriggs~~

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 24 1947

8. AGE: Years	Months	Days	If less than one day
		24	..... hrs. ..... min.

9. Birthplace Hagerstown Wash.Co. Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Charles Spriggs

13. Birthplace Great Capon W.Va.

MOTHER 14. Maiden name Elnore Fink

15. Birthplace Hancock. Md.

16. Informant Charles Spriggs

Address Hancock. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 16 1947 (month) (day) (year)

Cemetery or ~~crematory~~ Catholic

Location Hancock, Md.

18. Funeral director Snyder-Rowland

Address Hancock, Md.

19. Dec. 15, 1947 (Date rec'd by registrar) Chas. H. Rowerd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC. 14 1947, at 2:32 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 24 1947, to Dec. 14 1947 and that I last saw h[illegible] alive on December 14 1947

Immediate cause of death	DURATION
Pneumonia - stated as an aspiration pneumonia due to regurgitation and aspiration of food and Prematurity, the pneumonia then became broncho in character (12/27/48 ala)	2 days
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op. none.

Autopsy results none.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Aulis Robert Colvin M. D. ~~or other~~

Address Clear Spring Md Date signed 12/15/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11683

55 ex

Reg. Diat. No. 307

1. PLACE OF DEATH:

County: Washington

City or town: Chestnut Grove - Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution or street address where death occurred:

Robersville Md. R. 1.

How long in hospital or institution? at Home.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Chestnut Grove Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Robersville Md. R. 1

(If rural, give LOCATION)

2.(a) If veteran, name war: No Veteran

3.(a) FULL NAME: William McClure Stine

3.(b) Social Security Number: 214-10-1748

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Kathryn Himes Stine

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March - 8 - 1909

8. AGE:

Years	Months	Days	If less than one day
38	8	23	..... hrs. ..... min.

9. Birthplace: Near Teagarville Fred. Co. Md.
(Town, county, and state)

10. Usual occupation: Welder

11. Industry or business: Victor Products Corp. Hagerstown Md.

FATHER

12. Name: William C. Stine

13. Birthplace: Fred. Co. Md.

MOTHER

14. Maiden name: Adah Young

15. Birthplace: Fred. Co. Md.

16. Informant: Mrs. Kathryn Himes Stine

Address: Robersville Md. R. 1

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 3. 1947 (month) (day) (year)

Cemetery or crematory: Lutheran Cemetery

Location: Middletown Md

18. Funeral director: Wm. J. Rast & Sons

Address: Boonsboro Md.

19. Dec. 2 1947 (Date rec'd by registrar) Mrs. Katherine Degenhart Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 1 1947 at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 24 1947 to Dec 1 1947 and that I last saw h. alive on Nov. 30 1947

Immediate cause of death	DURATION
Melanic carcinoma	6 mos
Due to: Primary site: middle of back.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: G. W. Lilley M.D.
M. D. or other

Address: Boonsboro Date signed: 12/1/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

11684

CERTIFICATE OF DEATH

Reg. Diat. No. 305

1. PLACE OF DEATH:
County: Washington
City or town: Boonsboro
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, institution, or street address where death occurred:
Maple Ave.
How long in hospital or institution? at Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Boonsboro
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Maple Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: No.

3. (a) FULL NAME: Lora Ellen Stottlemyer

3. (b) Social Security Number: None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: W. W. Stottlemyer
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): February - 19 - 1876

8. AGE: Years: 71 | Months: 9 | Days: 24 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Beaver Creek Wash. Co. Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER
12. Name: Andrew Rideneur
13. Birthplace: Beaver Creek Wash. Co. Md.

MOTHER
14. Maiden name: Sarah Doyle.
15. Birthplace: Beaver Creek Wash. Co. Md

16. Informant: W. W. Stottlemyer
Address: Boonsboro Md.

17. Burial. (Burial, cremation, or removal. Which?) Date thereof: Dec. - 17 - 1947 (month) (day) (year)
Cemetery or crematory: Boonsboro Cemetery
Location: Boonsboro Md.

18. Funeral director: Wm. J. Bart & Son
Address: Boonsboro Md.

19. Dec. 16 1947 (Date rec'd by registrar) John W. Bert Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December - 13 1947, at 10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 2 1945, to December 13 1947 and that I last saw her alive on December 13 1947

Immediate cause of death	DURATION
Chronic Hypocardelitis —	2 yrs
Due to Cerebral Haemorrhage	2 Hrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury: ____ Injured at work?

23. SIGNATURE: G. W. Allan M. D. (M. D. or other)
Address: Boonsboro — Date signed: 12/15/47

Do not fold

W

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1600 11685

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County Washington
City or town Hagerstown md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 hours.
Hospital, institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution? 2 Hours.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Lantz md
(If outside city or town limits, write RURAL and give nearest town)
Street No. none
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Nellie K. Stottlemyer

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

8.(b) Name of husband or wife none

8.(c) If alive, give age none years

7. Birth date of deceased (mo., day, yr.) 12-27-1947

8. AGE: Years | Months | Days | If less than one day: 14 hrs. — min.

9. Birthplace Washington County Hospital
(Town, county, and state)

10. Usual occupation none

11. Industry or business none

FATHER 12. Name Otho Stottlemyer

13. Birthplace Lantz md

MOTHER 14. Maiden name Ruth Smith

15. Birthplace Lantz md

16. Informant Otho J. Stottlemyer

Address Lantz md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-31-1947 (month) (day) (year)

Cemetery or crematory Mt Pleasant Cemetery Columbia Pike

Location Pleasant Valley.

18. Funeral director Lud. B. Hoover

Address Smithsburg md

19. Dec 30, 1947 (Date rec'd by registrar) Clark H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 29 1947, at 1.30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 28 1947, to Dec 29 1947 and that I last saw h— alive on Dec 29 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage due to	15 days
Edema of Brain due to	15 days
Edema of Lungs due to	2 hrs
Placenta Previa Centralis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Placenta Previa Centralis Edema of Lungs Edema of Brain

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. C. Hollen M. D. or Other

Address Smithsburg Date signed 12/29/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Dr Porterfield

Dr. Porterfield

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

11686

Reg. Diat. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 Years

Hospital, Institution, or street address where death occurred:

904 Dewey Ave.

How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 904 Dewey Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war None

3.(a) FULL NAME FREDRICK JACOB STOUFFER

3.(b) Social Security Number 212-14-7012

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Daisey Stouffer

6.(c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) February 22, 1866

8. AGE: Years	Months	Days	If less than one day
81	9	14	....hrs. ....min.

9. Birthplace Hagerstown, Washington Co. Md. (Town, county, and state)

10. Usual occupation Merchant

11. Industry or business Retired

FATHER 12. Name Joseph Stouffer

13. Birthplace Hagerstown Md.

MOTHER 14. Maiden name Amielia Thomas

15. Birthplace Hagerstown Md.

16. Informant Mrs Daisey Stouffer

Address Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/9/47 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. 12/8 19 47 (Date rec'd by registrar) Chas. H. Bowers Dep't Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 6 19 47 at 11:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 24 1947 19 ... to Dec 6 19 47 and that I last saw h.im alive on Dec 6 19 47

Immediate cause of death	DURATION
Coronary Thrombosis	12/6/47
Due to arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE H. H. Porterfield M.D. M. D. or other

Address 136 W Washington Date signed 12/8/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Dr. Miller

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

92d

11687

CERTIFICATE OF DEATH

Reg. Diat. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 Years

Hospital, institution, or street address where death occurred:

1036 Marshall St.

How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1036 Marshall St.

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Otho J. Summers

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Martha Summers

6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): April 18, 1862

8. AGE: Years	Months	Days	If less than one day
85	7	16	..... hrs. ..... min.

9. Birthplace: Mapleville, Washington Co. Md.

(Town, county, and state)

10. Usual occupation: Cabinet Maker

11. Industry or business: Retired

FATHER 12. Name: Isaiah Summers

FATHER 13. Birthplace: Mapleville Md.

MOTHER 14. Maiden name: Rebecca Green

MOTHER 15. Birthplace: Mapleville Md,

16. Informant: Mrs Martha Summers

Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12/7/47 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown Md.

18. Funeral director: Andrew K. Coffman

Address: Hagerstown Md.

19. Dec 6. 1947 (Date rec'd by registrar) Chas H Hoover Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 4 19 47 at 5:30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1940 to 12/4 1947 and that I last saw h.. alive on 12/3 1947

Immediate cause of death	DURATION
arterio-sclerosis	2
chronic endocarditis.	
Due to: ✓	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE: V. Lee D. Miller M. D. or other

Address: Hagerstown Md Date signed: 12/5-1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11683

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 32 years

Hospital, institution, or street address where death occurred:

342 E. Franklin St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 342 E. Franklin St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Nell Luray Wagner

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	divorced

6.(b) Name of husband or wife: Frank Wagner

6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): September 23, 1893

8. AGE: Years	Months	Days	If less than one day
54	2	16	..... hrs. ..... min.

9. Birthplace: Greencastle, Franklin Co., Penna.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business:

FATHER
12. Name: Samuel Hays
13. Birthplace: Greencastle, Penna.

MOTHER
14. Maiden name: Lara Stoner
15. Birthplace: Greencastle, Penna.

16. Informant: Mrs. Paul Snyder
Address: Hagerstown, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 12-11-47 (month) (day) (year)
Cemetery or crematory: Green Hill Cemetery
Location: Greencastle, Penna.

18. Funeral director: Scott F. Minnich & Son
Address: Hagerstown, Md.

19. Dec. 11, 1947 (Date rec'd by registrar) Stuart H. Bowers, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 8, 1947, at 6:15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1 — 1947, to Dec 8 1947 and that I last saw h[illegible] alive on Dec 7 1947

Immediate cause of death	DURATION
Tuberculosis - Pulmonary	7 1
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Howard C. Rentzel M.D. M. D. or other

Address: Hagerstown Md. Date signed: 12/10/47

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

145

11689

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Wshington
City or town: Rural Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years
Hospital, Institution, or street address where death occurred: Hagerstown Rt. 5
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Rural Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Hagerstown Rt. 5
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Constance W. Williams

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Ivan M. Williams
6.(c) If alive, give age: 27 years

7. Birth date of deceased (mo., day, yr.): August 16, 1927

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
20	4	13		

9. Birthplace: Hagerstown Wash. Md.
(Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business: Own Home

FATHER
12. Name: Milton A. Bloom Sr.
13. Birthplace: Charmain Pa.

MOTHER
14. Maiden name: Eva M. Lumm
15. Birthplace: Beaver Creek Md.

16. Informant: Mr. Milton A. Bloom Sr.
Address: Hagerstown Rt. 5

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 31, 1947 (month) (day) (year)
Cemetery or crematory: Green Hill Cemetery
Location: Waynesboro Pa.
18. Funeral director: Scott F. Minnich & Son
Address: Hagerstown Md.

19. Dec. 30. 1947 (Date rec'd by registrar) Grant Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 29 1947, at 12:05a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 16 1947, to Dec 29 1947
and that I last saw h..er alive on Dec 19 1947

Immediate cause of death	DURATION
Sudden Death	
Cause undetermined	
FROM OTHER SIDE: . . died (see over)	
Due to: suddenly 12-29-47. . had recd adequate pre-	
Due to: natal care. . not in labor . in excellent	
health up to moment of death . Autopsy	
perf. Dec. 29 11 a.m. by Dr. Butterfield, Wash	
Co hosp. revealed no maternal or fetal ex-	
Other conditions: Pregnancy, undelivered 7 mos. planation.	

(Include pregnancy within 3 months of death)

Major findings of operation: Microscopic sections not yet completed. Dr. Robt V. Campbell 12/47
Date of op.
Autopsy results: inconclusive (from stillbirth certif.)

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [Robert Campbell] Robert V. Campbell M. D. or other: Md
Address: Hagerstown Date signed: Dec. 30 '47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

Mother died suddenly Dec. 29, 1947 - 12.05 A.M. Had received adequate pre-natal care. Mother was not in labor and in excellent health up to the moment of death. Autopsy performed 11 A.M. Dec. 29 by Dr. Butterfield Wash. Co. Hospital on mother revealed no maternal or fetal explanation. Microspic sections not yet completed.

Dr. Robt. V. L. Campbell
from stillbirth cert.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61 11690

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 Weeks.

Hospital, institution, or street address where death occurred:
Wash. Co. Hospital

How long in hospital or institution? 4 Weeks.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Boonsboro
(If outside city or town limits, write RURAL and give nearest town)

Street No.: N. Main St.
(If rural, give LOCATION)

2.(a) If veteran, name war: No.

3. (a) FULL NAME: Hubert Edgar Young

3. (b) Social Security Number: None.

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: Single

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 25 - 1872

8. AGE:

Years	Months	Days	If less than one day
75	1	26	..... hrs. ..... min.

9. Birthplace: near Boonsboro Wash. Co. Md.
(Town, county, and state)

10. Usual occupation: Retired Employee U.S.D. Dept.

11. Industry or business

FATHER
12. Name: John D. Young
13. Birthplace: Boonsboro Wash. Co. Md.

MOTHER
14. Maiden name: Jane Reeder
15. Birthplace: near Boonsboro Wash. Co. Md.

16. Informant: Mrs. John D. Young
Address: Boonsboro Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 23, 1947 (month) (day) (year)

Cemetery or crematory: Boonsboro Cemetery

Location: Boonsboro Md.

18. Funeral director: Wm. D. Bast & Sons

Address: Boonsboro Md.

19. Dec. 23. 1947 (Date rec'd by registrar) Chas. H. Boverd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 21 - 1947 at 4:30 a.m. P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 22d 1947, to Dec. 21st 1947 and that I last saw h... alive on Dec. 20th 1947

Immediate cause of death	DURATION
Prostatic Hypertrophy	—
Acute Uremia	2 weeks
Due to Arterio Nephritis	—
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. Leland Made M.D.
M. D. or other

Address: 1 Boonsboro Md. Date signed 12/22/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M